

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11154

11167

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3. V.O.I.-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1655 E. Cold Spring Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Wayne</b>	Middle <b>Elbert</b>	Last <b>Batton</b>	4. DATE OF DEATH <b>October</b>	Month <b>16</b>	Day <b>19</b>	Year <b>58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 30, 1920</b>	9. AGE (In years lost birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Henning Fielding Batton</b>		14. MOTHER'S MAIDEN NAME <b>Blanche (Margaret) Zervy</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-12-7177</b>		17. INFORMANT <b>Springfield Hospital Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH month							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leennac's cirrhosis.</b>		DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>581.1</b>		DUE TO							
{ (b) DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
ABS associated with alcoholism plus CBS associated with alcoholism									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>West Virginia</b>		(County) <b>West Virginia</b>	(State) <b>West Virginia</b>
21. I certify that I attended the deceased from <b>September 27, 1958</b> , to <b>October 16, 1958</b> , that I last saw the deceased alive on <b>October 16, 1958</b> , and that death occurred at <b>11:50 AM</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									
DATE SIGNED <b>10/16/58</b>									
ACTUAL SIGNATURE <i>Agustin del Campo</i>		M.D.		Springfield State Hospital					
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/19/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Sunset Memorial Cem.</b>		22d. LOCATION (City, town, or county) <b>West Virginia</b>		(State) <b>West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George J. Ruck</i>		ADDRESS <b>5305 Hawley St.</b>		24a. REC'D BY REGISTRAR <b>OCT 20 1958</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral-director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

對亞洲第一大經濟體中國大陸的影響

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11155

11168

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Carroll</i>				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rural Manchester #1				Manchester #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
<i>Clinton</i>				<i>Baughman</i>	<i>October 26 1958</i>
5. SEX		6. COLOR OF RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.
<i>M</i>				<i>5/2/1882</i>	<i>76</i>
10a. USUAL OCCUPATION (Give kind of work done) Cultivating most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		10c. BIRTHPLACE (State or foreign country)	
<i>retired 1958</i>		<i>Canning</i>		<i>Carroll Co Md</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<i>George Baughman</i>		<i>Unknown</i>		<i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. GRIEVANT Address	
<i>No</i>		<i>213-18-8601</i>		<i>Carl C Baughman, 100 W. Main St. #1</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b); and (c))		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cerebral Hemorrhage</i>			
<i>331X</i>		6 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>Hypertension</i>			
(b)		5 yrs			
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I attended the deceased from <i>Nov 4</i> , 1958, to <i>Oct 26</i> , 1958, that I last saw the deceased alive on <i>Oct 25</i> , 1958, and that death occurred at <i>3A</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>W.H. Board</i>		<i>Manchester Md 10-27-58</i>			
PHYSICIAN'S NAME (Type) <i>W.H. Board, M.D.</i>		DATE SIGNED			
22a. FUNERAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/29/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Paul's Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Pg Rd York C.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick Buckner Janus</i>		ADDRESS <i>59</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 28 58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2025 RELEASE UNDER E.O. 14176 - TEXAS STATE DMV 12-201

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11169

## CERTIFICATE OF DEATH

Reg. Dist. No.

11156

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Union Mills</b>		c. LENGTH OF STAY IN lb <b>9 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>27 Westminster</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Meadow View Convalescent Home</b>				d. STREET ADDRESS <b>1 173 W. Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Effie</b>		First <b>Elizabeth</b>	Middle <b>Belt</b>	last <b>October 15,</b>	Month <b>1958</b>	Day <b>19</b>	Year <b>58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 20, 1869</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>	12. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles M. Hess</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Bushey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. M. Ross Fair, Taneytown, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4222</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Chronic hepatitis complicated by chronic hepatitis.</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>10/15/58</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/15/58</b> to <b>10/15/58</b> that I last saw the deceased alive on <b>10/15/58</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur Bore</b>		ADDRESS (Street, city or town, state) <b>Widewater Ave.</b>					
PHYSICIAN'S NAME (Type) <b>S. L. OTHER BARE</b>		DATE SIGNED <b>10/17/58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 18, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merlyn C. Fuss</b>				ADDRESS <b>C.O. Fuss &amp; Son, Taneytown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 20 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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#### REFERENCES

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11170

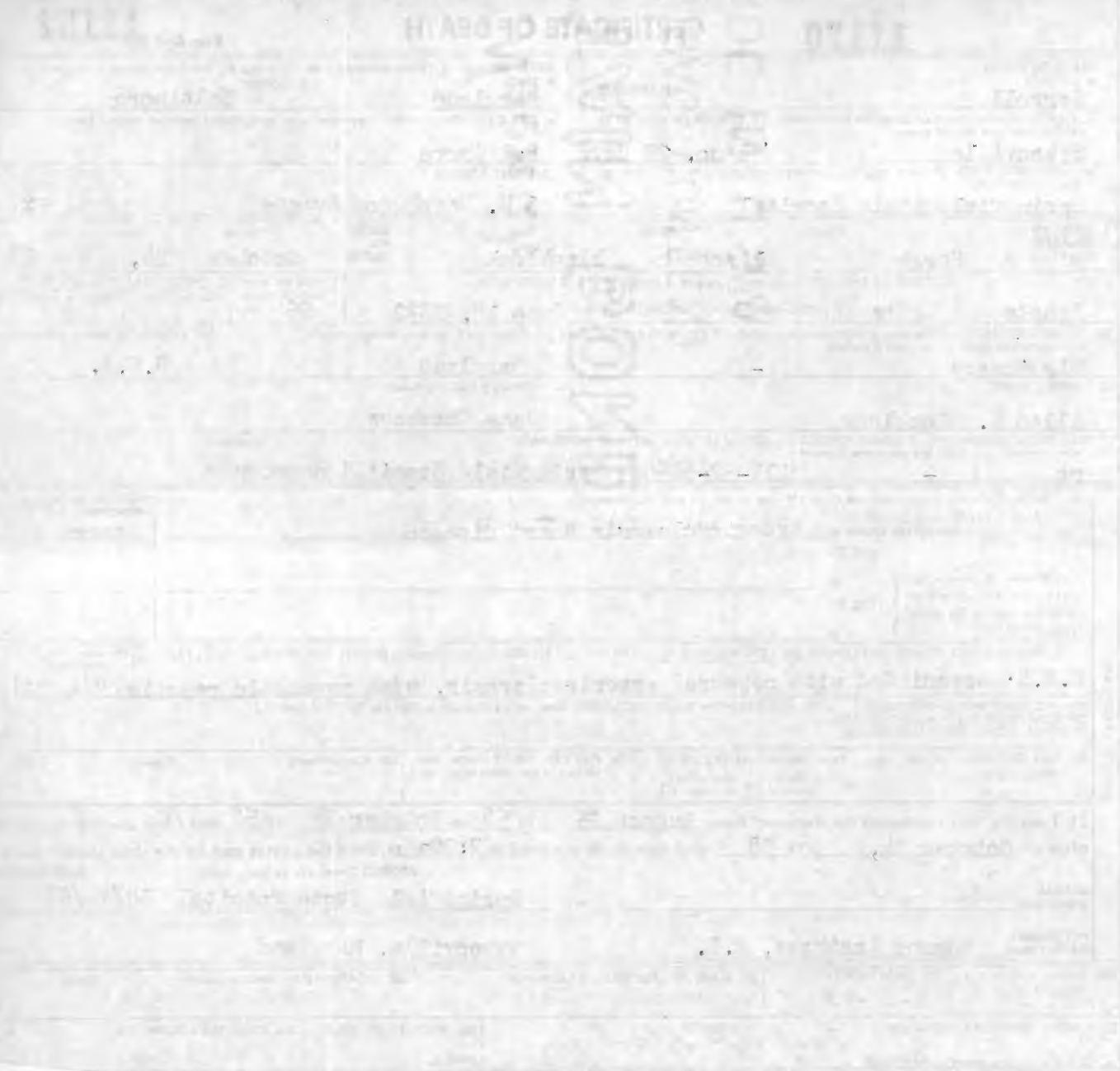
## CERTIFICATE OF DEATH

Reg. Dist. No.

11157

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 29 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 28</b>		d. STREET ADDRESS <b>3 N. Beechwood Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sarah</b>		First	Middle	4. DATE OF DEATH <b>October 24, 1958</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1872</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Missionary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Allan R. Blacklock</b>		14. MOTHER'S MAIDEN NAME <b>Jane Chambers</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-32-6456</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriosclerosis heart disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
		INTERVAL BETWEEN ONSET AND DEATH years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>August 25, 1958</b> , to <b>October 24, 1958</b> , that I last saw the deceased alive on <b>October 24, 1958</b> , and that death occurred at <b>2:00a M</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		DATE SIGNED 10/24/58					
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-27-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Farley J. L. Home</i>		ADDRESS <b>Fresh &amp; Shady Rock Ave. Catonsville, Md.</b>	24a. REC'D BY REGISTRAR <b>OCT 31 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11158

## 11171 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>ly 2 m 9 d</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Archie</b>		First <b>Nataniel</b>	Middle <b>Bowen</b>
4. DATE OF DEATH <b>10</b>	Month <b>10</b>	Day <b>3</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-98</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR; IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unkn</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seaman</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Arthur Bowen</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>unkn</b>		17. INFORMANT <b>S.S. Hospital Records</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause lost. (b) DUE TO (c)			
C.B.5. assoc.with circulatory disturbance with cerebral arterioscler. with psych.reaction.Palm.Tuberculosis mod.advanced,inactive		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>002X</b>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <b>10-3-1958</b> , and that death occurred at <b>11:05 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Edmund Lusthaus</b> M.D. Springfield State Hospital <b>10-4-58.</b>	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/7/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC.</b>		ADDRESS <b>715 Light St.</b>	24a. REC'D BY REGISTRAR DATE <b>OCT 8 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF

CERTIFICATE OF DEATH

Death Record

File No.

Date of Birth \_\_\_\_\_

Date of Death \_\_\_\_\_

Place of Birth \_\_\_\_\_

Place of Death \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_

Country \_\_\_\_\_

State \_\_\_\_\_

City \_\_\_\_\_

Street \_\_\_\_\_

Apartment \_\_\_\_\_

Telephone \_\_\_\_\_

Relationship to Deceased \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Relationship to Deceased \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11172

## CERTIFICATE OF DEATH

11159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel County</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>	c LENGTH OF STAY IN 1b <b>91 days</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harwood Route 2, P.O.</b>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

03

3 NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>Alexander</b>	Last <b>Butler</b>	4. DATE OF DEATH	Month <b>October</b>	Day <b>1</b>	Year <b>19 58</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-18-06</b>	9. AGE (In years last birthday) <b>51 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Harry Butler</b>	14 MOTHER'S MAIDEN NAME <b>Maggie Savoy</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO <b>213-004-0574</b>	17. INFORMANT <b>William A. Butler</b>	Address <b>Route #2, P.O. Anne Arundel Harwood, Maryland</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Far advanced bilateral cavitary pulmonary Tbc.</b> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

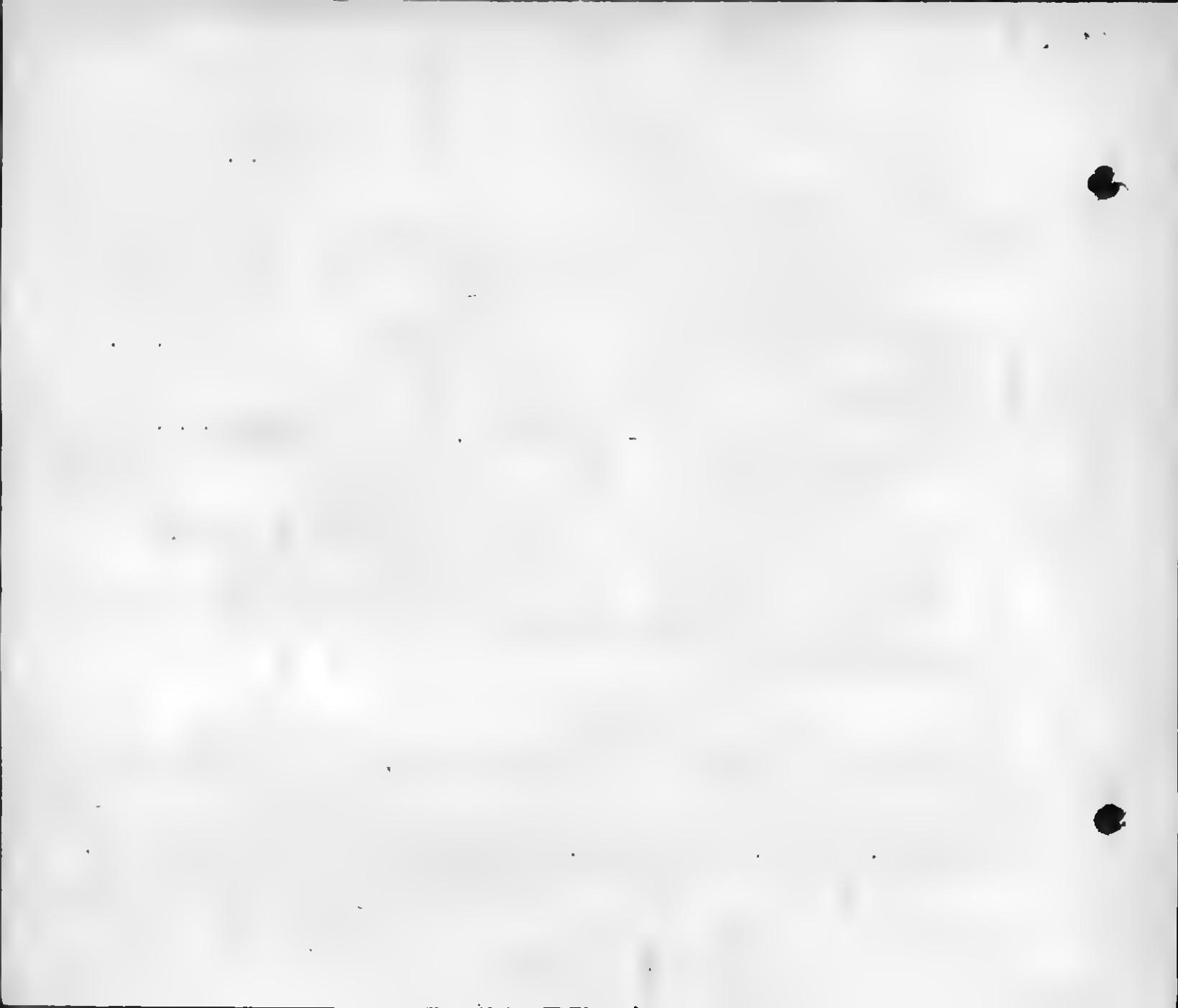
21. I certify that I attended the deceased from <b>July 2, 19 58</b> to <b>October 1, 19 58</b> , that I last saw the deceased alive on <b>October 1, 19 58</b> , and that death occurred at <b>8:45P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE <i>E. M. Maculans</i>	M.D.	Henryton, Maryland	<b>10-1-58</b>
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PHYSICIAN'S NAME (Type)	Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.		
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22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 10-8-58</b>	22b. DATE THEREOF <b>10-8-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Clarks Chapel A.F.C.</b>	22d. LOCATION (City, town, or county) <b>MD</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>J.W. Reese</i>	ADDRESS <i>Ann Arbor, Mich</i>	24a. REC'D BY REGISTRAR DATE <b>10-1-58 OCT 7 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>
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11160

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11173 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be handed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director or files of the Health Department.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>5 yrs. 2 mos. 14 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. STREET ADDRESS <b>5609 Roosevelt St.</b>	
f. IS PERT OF ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Jane</b>	Middle <b>Baird</b>	Last <b>CAPNESECCHI</b>
4. SEX <b>Female</b>	5. COLOR OR RACE <b>White</b>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <b>February 1, 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -	
10c. FATHER'S NAME <b>Samuel Patterson</b>		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. MOTHER'S MAIDEN NAME <b>Agnes Muir</b>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		15. SOCIAL SECURITY NO. -	
16. INFORMANT Address <b>Springfield Hospital Records</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerosis</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Jane T. Marsh, M.D.</i>	DATE SIGNED <b>10/17/58</b>		
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>10/20/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) <b>Shady Suitland, Maryland</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>OCT 20 58</b>	24b. REGISTRAR'S SIGNATURE <b>Curry &amp; Evans</b>



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 9 File # 11161-3-58 et Reg. Dist. No.  
TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Health Department or its designated agent, prior to burial, cremation, or removal, and is only valid within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11161									
		11161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
		Item 9 File # 11161-3-58 et Reg. Dist. No.																			
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission)																			
a. COUNTY		b. STATE										Reg. Dist. No.									
CARROLL COUNTY		MARYLAND										CARROLL									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b										e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
WESTMINSTER		35 yrs										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS																			
		#10 WILLOW AVE.																			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year							
HARRY		MONTROSE		CHEW		april 1, 1901		10 / 21 / 1958		IF UNDER 1 YEAR		IF UNDER 24 HRS									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years on birthday)		Months		Days		Hours Min							
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		april 1, 1901		57 5 8 yrs													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)										12. CITIZEN OF WHAT COUNTRY?							
WESTERN MARYLAND RAILROAD EMPLOYEE				FINKSBURG MD.										U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME										Address									
CHARLES CHEW		FANNY B. CHEW nee ??																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]															
No, as unknown		WVI SEPT 1919 - Sept 216-03-2978		WIFE - MRS. MARY L. CHEW		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 816 X DUE TO															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)				Crushed Chest & Internal Injuries															
(c)						INTERVAL BETWEEN ONSET AND DEATH minutes															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE CONDITION GIVEN IN PART I(a)										20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter cause of injury in Part I or Part II of Item 18)							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												Run his Car into rear end of tractor trailer		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED Month, Day, Year		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
8 p.m.		10/21 1958										White Not white		at work <input type="checkbox"/> at work <input type="checkbox"/>		845 Route 140		Westminster Carroll md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE										MD CHIEF MEDICAL EXAMINER <input type="checkbox"/>		EXAMINER'S NAME (Type)		DATE SIGNED					
Wylene Speicher		Acting										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		10/21/58					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR Crematory		22d. LOCATION (City, town, or county)															
BURIAL		10/25/58		BETHEL CENTER		PEESKE															
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE															
James J. Sofield Westminster Md.		258 1/2 main St.		DATE OCT 24 '58		Cathleen S. Trahan															



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11162

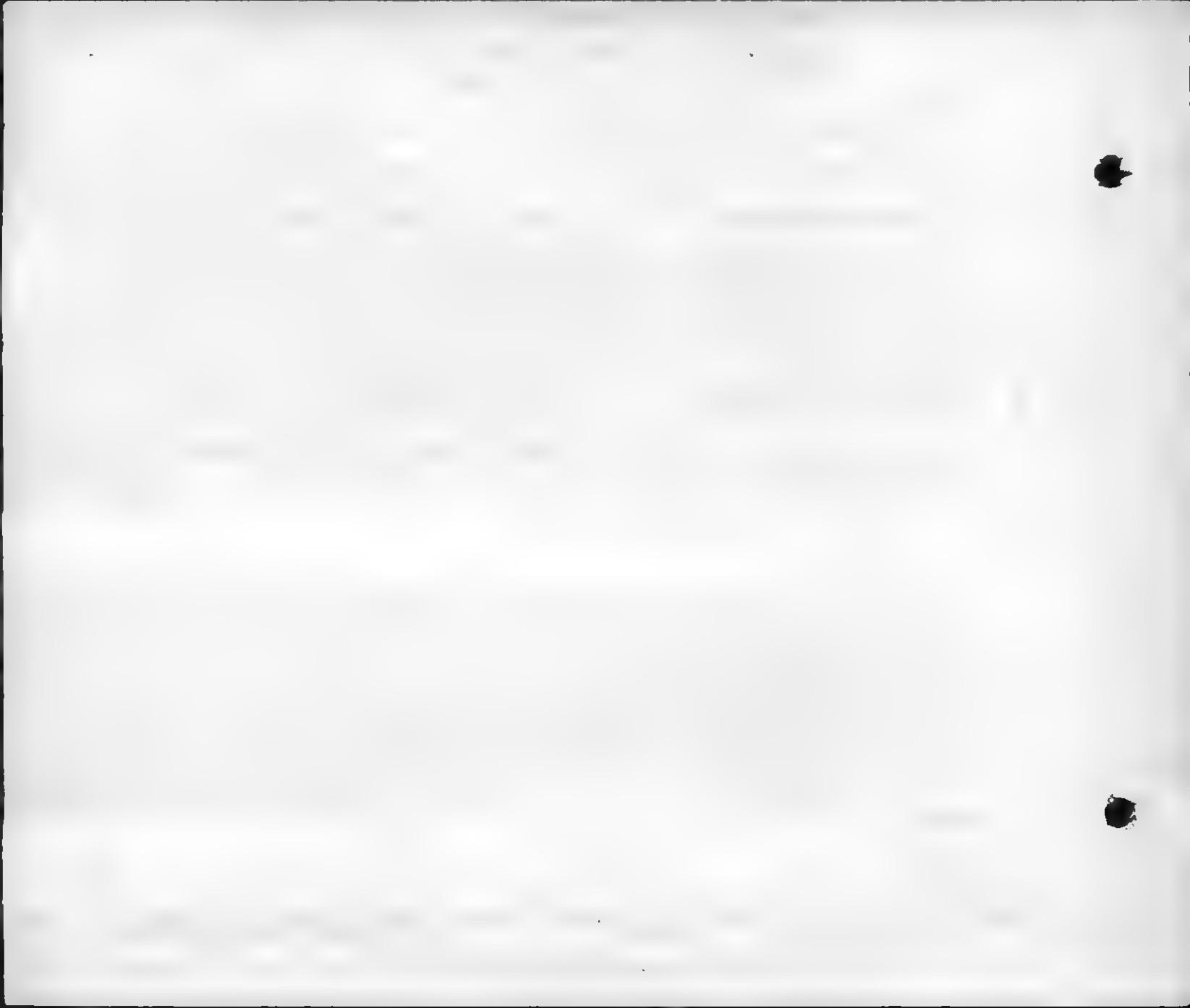
## CERTIFICATE OF DEATH

11162

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>80 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>204 Penna. Ave.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. STREET ADDRESS <u>204 Penna. Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>JESSE</u>	Middle <u>FRANCIS</u>	Last <u>CHREST</u>
4. DATE OF DEATH	Month <u>OCT.</u>	Day <u>18</u>	Year <u>1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15 1878</u>
9. AGE (In years lost, birthday) <u>80 yrs.</u>	10. IF UNDER 1 YEAR <u>Months</u>	11. IF UNDER 24 HRS. <u>Days</u>	12. IF UNDER 24 HRS. <u>Hours</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH, Self employed</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>WESTMINSTER, MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>GEORGE A. CHREST</u>	14. MOTHER'S MAIDEN NAME <u>MARGARET J. FOWLER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>MISS LILLIAN L. CHREST, WESTMINSTER, MD.</u>	Address <u>(204 Penna Ave.)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks from onset</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5115 1/2 M.</u>
20f. (City or town) (County) <u>103</u> (State) <u>Westminster, MD</u>			
21. I certify that I attended the deceased from <u>May 1948</u> to <u>Oct 18-58</u> , that I last saw the deceased alive on <u>Oct 18-58</u> , and that death occurred at <u>5115 1/2 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. C. Jeannette</u>	ADDRESS (Street, city or town, state) <u>103 N Main Westminster MD</u>		
PHYSICIAN'S NAME (Type) <u>Wm. C. Jeannette M.D.</u>	DATE SIGNED <u>10-22-58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 22, 58</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>LEISTER'S CEMETERY RURAL WESTMINSTER, MD.</u>	22d. LOCATION (City, town, or county) <u>RURAL WESTMINSTER, MD.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr. Westminster, MD.</u>	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Trahan</u>
VS A1S (4) 1SM 9/55		DATE <u>OCT 22 '58</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11174

## CERTIFICATE OF DEATH

11163

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

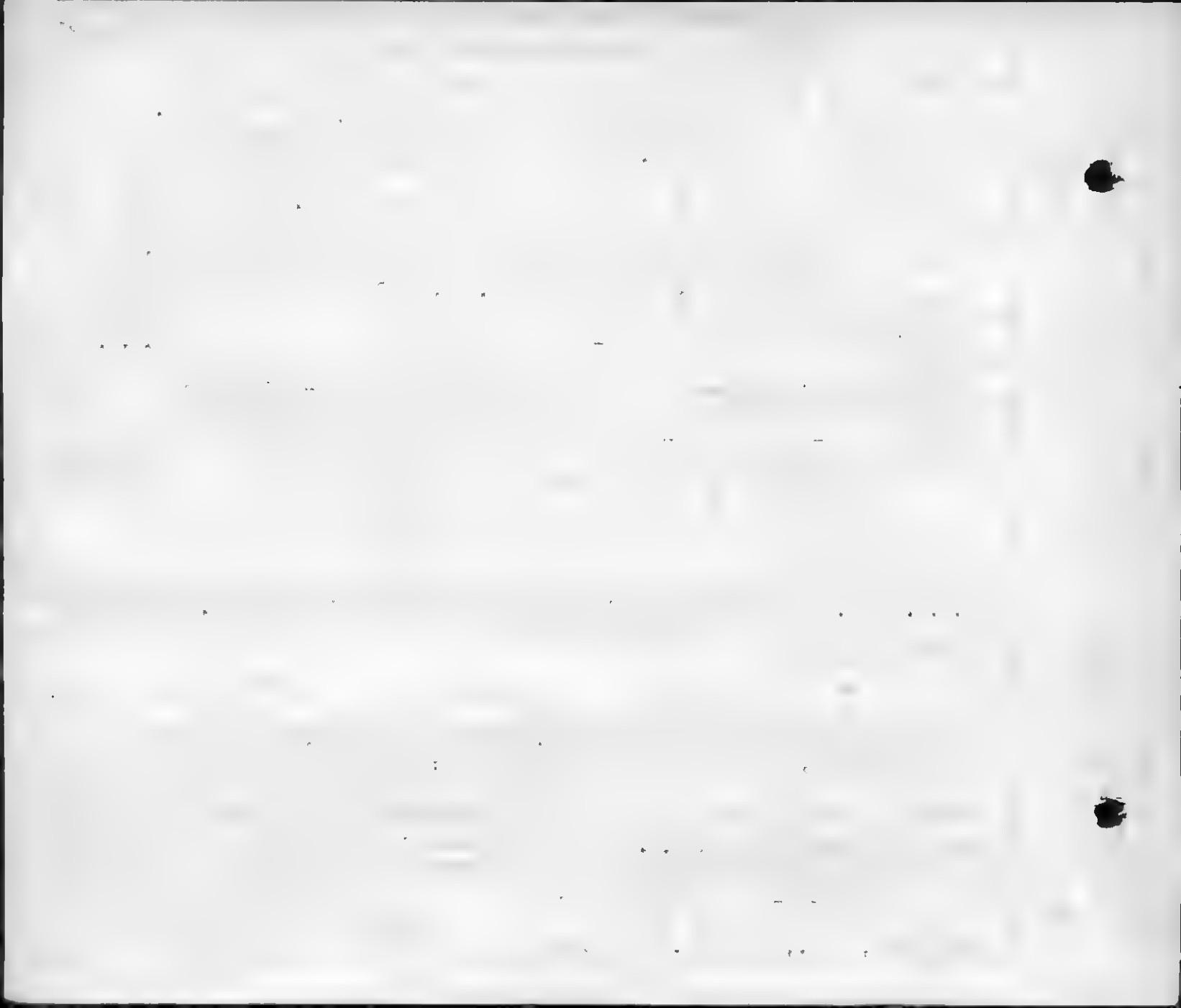
1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. LENGTH OF STAY IN b <i>24 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Emmitsburg</i>		d. STREET ADDRESS <i>East Main</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longmeadow Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Edwin</i>		First <i>Edwin</i>	Middle <i></i>	Lost <i>Chrismer</i>	4. DATE OF DEATH <i>October</i>	Month <i>9.</i>	Day <i>1958</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 6, 1866.</i>	9. AGE (In years lost birthday) <i>91 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wheelwright</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carriage Maker</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>		
13. FATHER'S NAME <i>John A. Chrismer</i>		14. MOTHER'S MAIDEN NAME <i>Susan Cadore</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Wayde Chrismer, Bel Air Maryland.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Cerebral Sclerotic Cardiovascular Disease				INTERVAL BETWEEN ONSET AND DEATH		
Fracture Left Femur.		Generalized Atherosclerosis						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell out of bed on left hip - 9/21/58.</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour <i>10 p.m. 9-21-1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Nursing Home</i>		20f. (City or town) <i>Manchester Carroll</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Sept 12</i> , 1958, to <i>October 9</i> , 1958, that I last saw the deceased alive on <i>October 7</i> , 1958, and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>Joseph E. Bush</i>		M.D.		<i>Hampstead Md</i>		DATE SIGNED <i>10-9-58</i>		
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>				<i>Hampstead Md</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 11, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Joseph's Catholic</i>		22d. LOCATION (City, town, or county) <i>Emmitsburg, Frederick Co.</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. L. Allison</i>		ADDRESS <i>Emmitsburg, Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Knapp</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>		
				DATE <i>Oct 14 '58</i>				



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11175 CERTIFICATE OF DEATH										11164					
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND										Reg. Dist. No.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville					c. LENGTH OF STAY IN lb 6mos. 10days					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Balt. City					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13										
3. NAME OF DECEASED (Type or print) First Ida Middle Grace Thompson Lost					d. STREET ADDRESS 3438 Elmora Ave.					d. DATE OF DEATH October Month 7, Day Year October 7, 1958					
e. SEX Female		f. COLOR OR RACE White		g. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		h. DATE OF BIRTH Sept. 25, 1871		i. AGE (In years last birthday) 87 yrs.		j. IF UNDER 1 YEAR Months Days Hours Min					
k. DIVORCED <input checked="" type="checkbox"/>		l. WIDOWED <input checked="" type="checkbox"/>													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Andrew Thompson Wheeler					14. MOTHER'S MAIDEN NAME Laura Josephine Mackheimer					Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT											
No		-		Springfield Hospital Records											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH Years 420.0															
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I attended the deceased from March 27, 1958, to October 7, 1958, that I last saw the deceased alive on October 7, 1958, and that death occurred at 7:45P M, from the causes and on the date stated above.															
ADDRESS (Street, city or town, state)															
DATE SIGNED 10/8/58															
ACTUAL SIGNATURE Edmund Lusthaus, M.D.															
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Springfield State Hospital															
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-10-58		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park		22d. LOCATION (City, town, or county) Baltimore		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street					ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus						



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11176

## CERTIFICATE OF DEATH

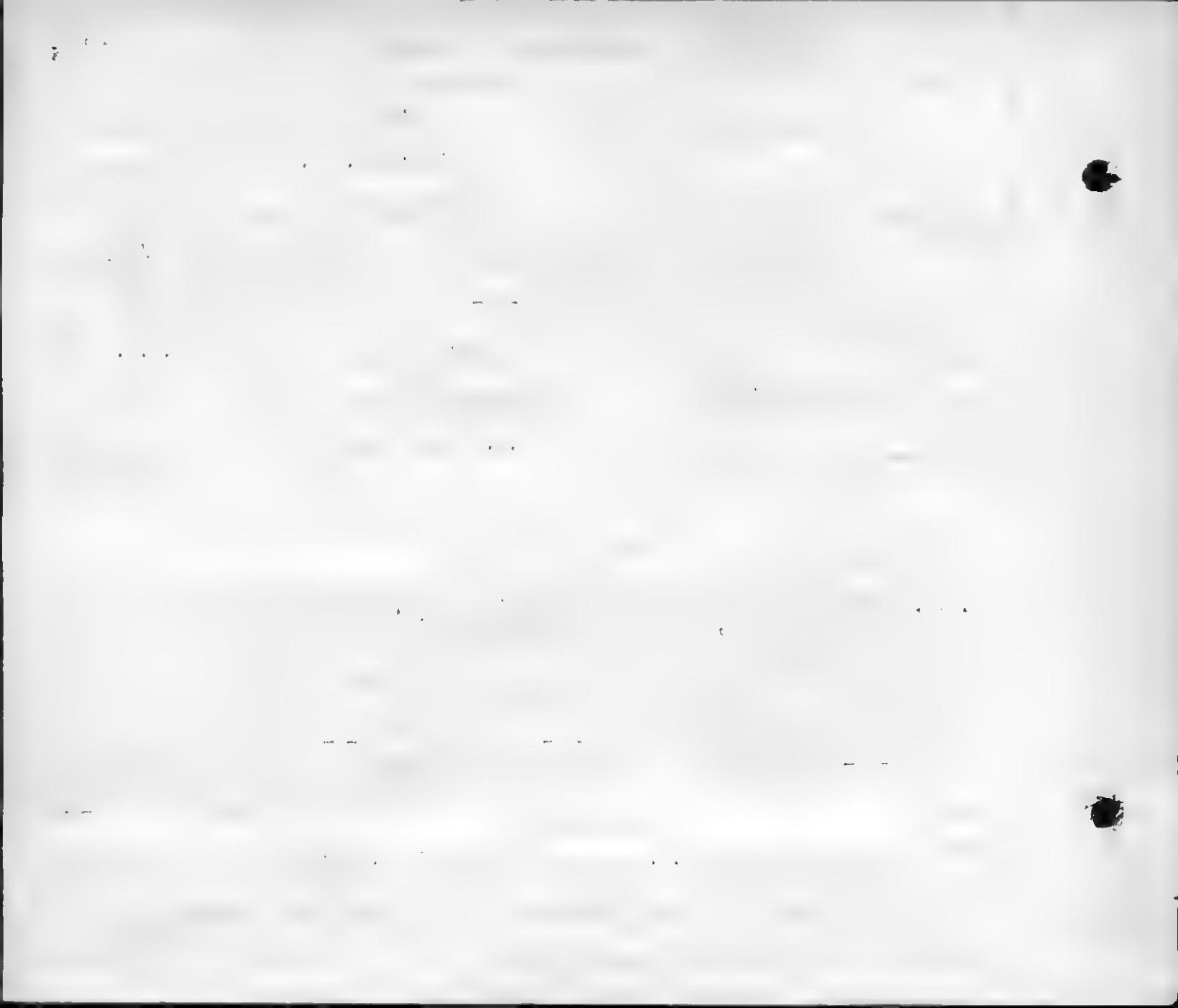
11165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 y 6 m 6 d</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Harry</b>	Middle <b>Joseph</b>	Last <b>Dixon</b>	4. DATE OF DEATH <b>10</b>	Month <b>10</b>	Day <b>(4)</b>	Year <b>19 58</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-27-90</b>	9. AGE (In years last birthday) <b>68</b> yr.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>shipwork</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Robert Joseph Dixon</b>				14. MOTHER'S MAIDEN NAME <b>Maria Mc Namee</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>unkn</b>		17. INFORMANT <b>S.S. Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Branchopneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>days</b> 471x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
C.B.P. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? <b>Pulmonary tuberculosis, moderately advanced, inactive</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>002X</b>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(City or town) (County) (State)		
21. I certify that I attended the deceased from <b>3-27-</b> , 19 <b>57</b> , to <b>10-3-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10-3-</b> , 19 <b>58</b> , and that death occurred at <b>1:53A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>Edmund Lusthaus</b> <b>10-4-58.</b>								
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> ADDRESS <b>Sykesville, Maryland</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/7/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cathedral</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Flynn &amp; Fleming, 1422 Light St.</b>		ADDRESS		24a. REG'D BY REGISTRAR <b>OCT 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>G. J. Hart &amp; Son</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11177

## CERTIFICATE OF DEATH

11166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN lb 5mos.28 days		a. STATE Maryland b. COUNTY Garrett	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ---	
3. NAME OF DECEASED (Type or print) First Jacob		Middle Walter		4. DATE OF DEATH DOVE	Month October Day 27 Year 1958
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 9-6-81	9. AGE (in years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		10b. KIND OF BUSINESS OR INDUSTRY Coal mining		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? United States					
13. FATHER'S NAME Isiah Dove		14. MOTHER'S MAIDEN NAME Kathryn Souders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO unknown		17. INFORMANT Records of Springfield State Hospital	
Address Sykesville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ---				INTERVAL BETWEEN ONSET AND DEATH 3 days more than 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) chronic brain syndrome associated with cerebral arterio-sclerosis, with psychotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---				(County) (State)	
21. I certify that I attended the deceased from April 29, 1958, to Oct. 27, 1958, that I last saw the deceased alive on Oct. 26, 1958, and that death occurred at 9:50 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Walter Knopp, M. D. Springfield State Hospital DATE SIGNED 10-28-58					
ACTUAL SIGNATURE Walter Knopp, M. D.		Sykesville, Maryland			
PHYSICIAN'S NAME (Type) Walter Knopp, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/58		22c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery & Mortuary, Sykesville, Md.	
22d. LOCATION (City, town, or county) ---		(State)			
23. FUNERAL-DIRECTOR'S SIGNATURE Freddie A. Haught Sykesville, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 3 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11178 CERTIFICATE OF DEATH

11167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>	c. LENGTH OF STAY IN lb <b>2 mths 14 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14, Md.</b>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>	e. STREET ADDRESS <b>2914 Joppa Road</b>	f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Sarah Elizabeth Guerke</b>	First <b>Sarah</b>	Middle <b>Elizabeth</b>	Last <b>Guerke</b>	4. DATE OF DEATH <b>10-5-58</b>	Month <b>10</b>	Day <b>5</b>	Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-67</b>	9. AGE (In years (at birthday) yrs.) <b>91</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Daniel Joyner</b>			14. MOTHER'S MAIDEN NAME <b>Amanda Flower</b>			Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>unkn</b>		17. INFORMANT <b>S.S. Hospital Records</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with senile brain disease with psych. reaction</b>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Springfield State Hospital</b>		(County) <b>M.D.</b>	(State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>7-21-1958</b> to <b>10-4-1958</b> , that I last saw the deceased alive on <b>10-4-1958</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	DATE SIGNED <b>10-5-58</b>
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		NAME (Type) <b>Edmund Lusthaus M.D.</b>							Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>10-8-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>OAKLAWN</b>		22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorraine J. Luck</b>		ADDRESS <b>5305 Highland</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Curley S. Thrane</b>				



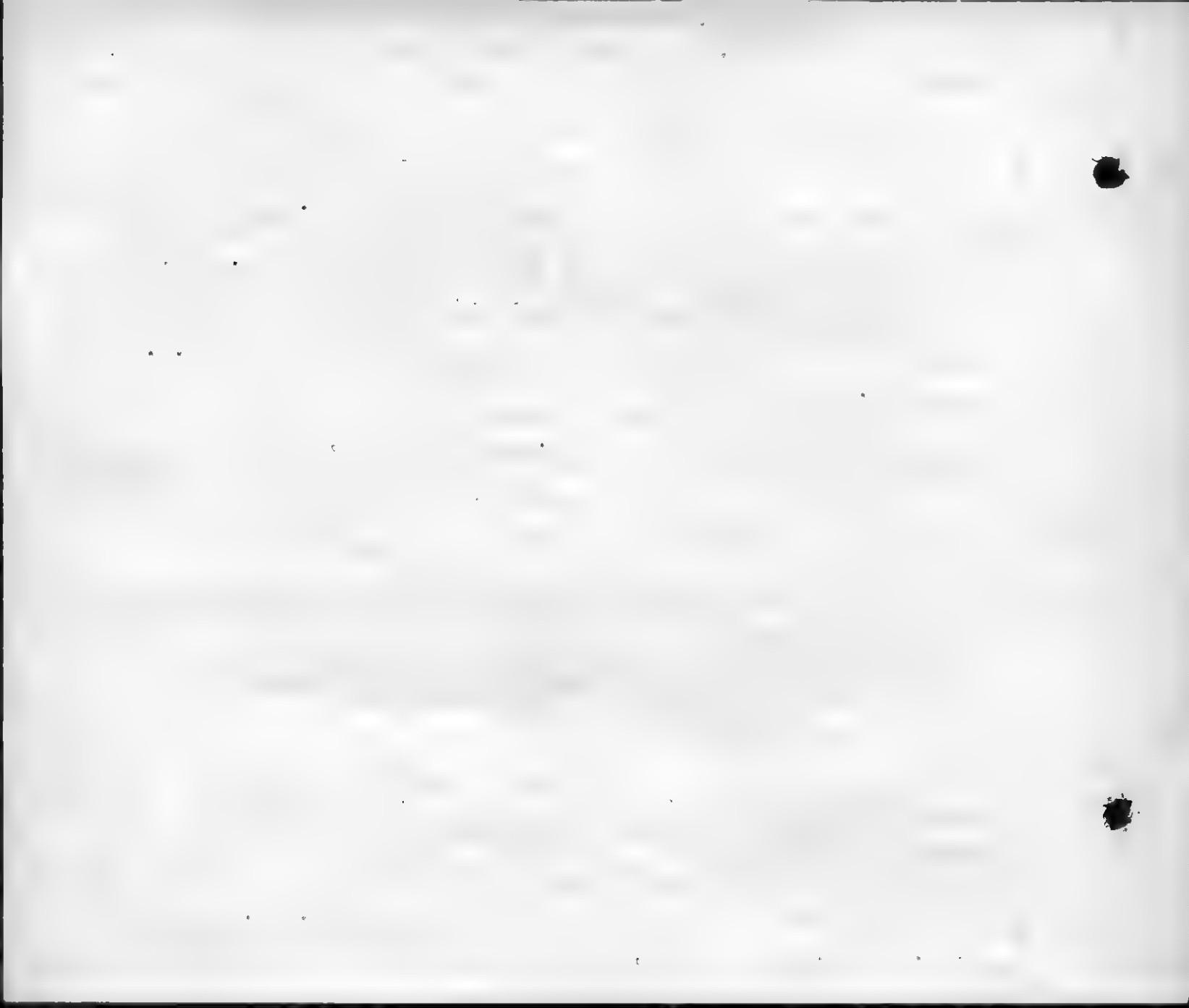
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11179. CERTIFICATE OF DEATH**

11168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY      CARROLL      MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE      Maryland      b. COUNTY      Carroll													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ** Sykesville				c. LENGTH OF STAY IN 1b 2 yrs													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
d. STREET ADDRESS Klee Mill Rd.																	
3. NAME OF DECEASED (Type or print)		First DALE	Middle ALLEN	Last HAWKINS	4. DATE OF DEATH OCT. 25,	Month 19 58	Day Year										
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-1956	9. AGE (In years last birthday) 2 yrs	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS Days Hours Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.											
13. FATHER'S NAME W. LeRoy Hawkins		14. MOTHER'S MAIDEN NAME Shirley Murray															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT W. LeRoy Hawkins, Same		Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Fractured skull		INTERVAL BETWEEN ONSET AND DEATH Instant													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO		(c)													
MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I(a) of item 18) Boy fell off of car & front of sheep apparently from car reversed				20c. TIME OF INJURY Month, Day, Year Hour 12/15 p.m. 10/25 1958		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) New Carrollton		20f. (City or town) Sykesville Carroll Md		(County) Md		(State)	
21. I certify that I attended the deceased from 10/25, 1958, to 10/25, 1958, that I last saw the deceased alive on 10/25, 1958, and that death occurred at 12:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)				DATE SIGNED											
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		William Speicher M.D. acting Deputy Medical Examiner				10/25/58											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-1958		22c. NAME OF CEMETERY OR CREMATORIAL Deer Park		22d. LOCATION (City, town, or county) Balto. Co. Maryland											
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE OCT 27 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11163

## CERTIFICATE OF DEATH

11169

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

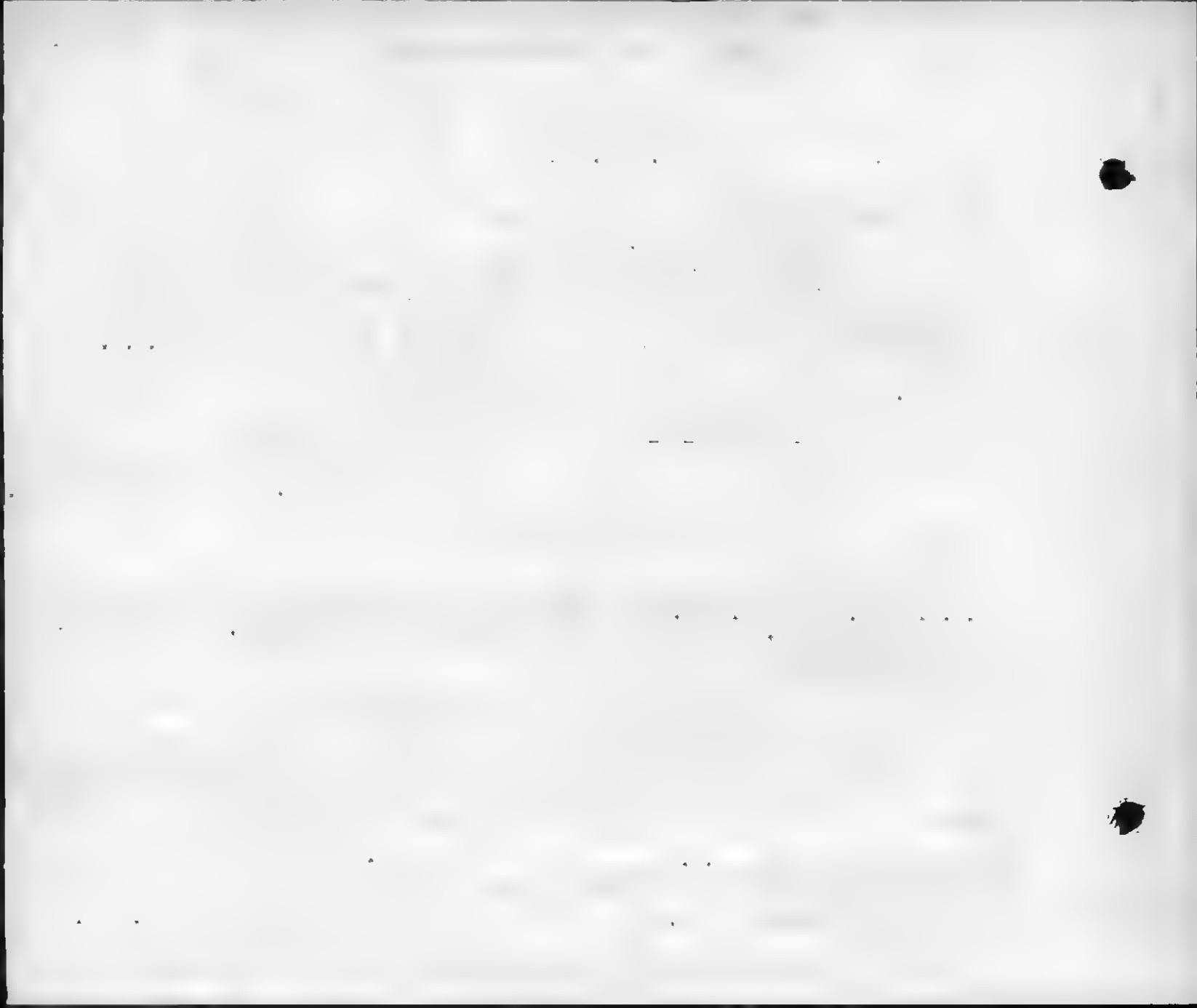
1. PLACE OF DEATH a. COUNTY <i>Carroll Co.</i>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN 1b <i>10 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		d. STREET ADDRESS <i>1775 - Main St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>175 - Main St.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>FLORA</i>	Middle <i>ELIZABETH</i>	Last <i>HILTABRIDGE</i>	4. DATE OF DEATH Month <i>OCT.</i>	Day <i>4</i>	Year <i>1958</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 30, 1871</i>	9. AGE (In years lost birthday) yrs. <i>87</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. U.S. JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>WILLIAM HILTABRIDGE</i>		14. MOTHER'S MAIDEN NAME <i>REBECCA DAYHOFF</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO <i>-</i>		17. INFORMANT <i>Roy Hiltabridge Westminster, Md.</i>		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1112 x</i>		Chronic myocarditis DUE TO Hypertension & Central Hemorrhage 1950		INTERVAL BETWEEN ONSET AND DEATH <i>yes</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Arteriosclerotic Cardio 10-15 yrs				
(c)		Renal Disease 8-10 yrs				
Chronic myocarditis DUE TO Hypertension & Central Hemorrhage 1950		Arteriosclerotic Cardio 10-15 yrs				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>-</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>:60X</i>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Sept 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept</i> , 1950, to <i>Oct 4</i> , 1958, that I last saw the deceased alive on <i>Oct 4</i> , 1958, and that death occurred at <i>11:15 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Westminster, Md.</i>		DATE SIGNED <i>10/6/58</i>
ACTUAL SIGNATURE <i>Weber Speicher</i>		PHYSICIAN'S NAME (Type) <i>Weber Speicher</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 7, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Bearfoot Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Westminster, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers Jr., Westminster, Md.</i>		ADDRESS <i>-</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 8 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Faure</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 11170
11180 CERTIFICATE OF DEATH										
1. PLACE OF DEATH o COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville,			c. LENGTH OF STAY IN lb 2yrs. 4mos. 19days X			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					d. STREET ADDRESS RFD #2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Harry	Middle Francis	Last Hooper	4. DATE OF DEATH October		Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 25, 1883		9. AGE (In years lost birthday) 74 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Joseph F. Hooper				14. MOTHER'S MAIDEN NAME Lilly Jones						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 220-10-9627		17. INFORMANT Springfield Hospital Records		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Arteriosclerotic cardiovascular disease. DUE TO 422.1										INTERVAL BETWEEN ONSET AND DEATH More than 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										
C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction. Left direct inguinal hernia with obstruction. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE LEADING DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from May 18, 1956 to October 7, 1958, that I last saw the deceased alive on October 6, 1958, and that death occurred at 8:25A M, from the causes and on the date stated above										ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE Walter Knapp, M.D.		Springfield State Hospital								DATE SIGNED 10/7/58
PHYSICIAN'S NAME (Type) Walter Knapp, M.D.		Sykesville, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery			22d. LOCATION (City, town, or county) Silver Run, Carroll Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Richard H. Littlestone Jr.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 9 '58			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11181 CERTIFICATE OF DEATH

11171

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>371 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>47 N. West Street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Mentheolia</b>		First	Middle	Last	4. DATE OF DEATH <b>October 3, 1958</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-1925</b>	9. AGE (In years last birthday) <b>33 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Irvin James</b>		14. MOTHER'S MAIDEN NAME <b>Esther Lomax</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mentheolia Jones</b>		Address <b>47 N. West Street</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>nix</b>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Tuberculoma of the brain		INTERVAL BETWEEN ONSET AND DEATH		
DUE TO (c)				Tuberculous Meningitis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Henryton, Maryland</b>		(State)
21. I certify that I attended the deceased from <b>Sept. 27, 1957</b> , to <b>Oct. 3, 1958</b> , that I last saw the deceased alive on <b>October 3, 1958</b> , and that death occurred at <b>2:05 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>		DATE SIGNED <b>10-3-58</b>
ACTUAL SIGNATURE <b>E. M. Maculans</b>		M.D.						
PHYSICIAN'S NAME (Type) <b>Dr. E. M. Maculans, Supt.</b>				Henryton State Hospital, Henryton, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-7-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Brewer Hill</b>		22d. LOCATION (City, town, or county) <b>Annapolis - Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks</b>		ADDRESS <b>II Annapolis-Md</b>		24a. REC'D BY REGISTRAR DATE OCT 8 '58		24b. REGISTRAR'S SIGNATURE <b>C. E. Hicks</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11182

## CERTIFICATE OF DEATH

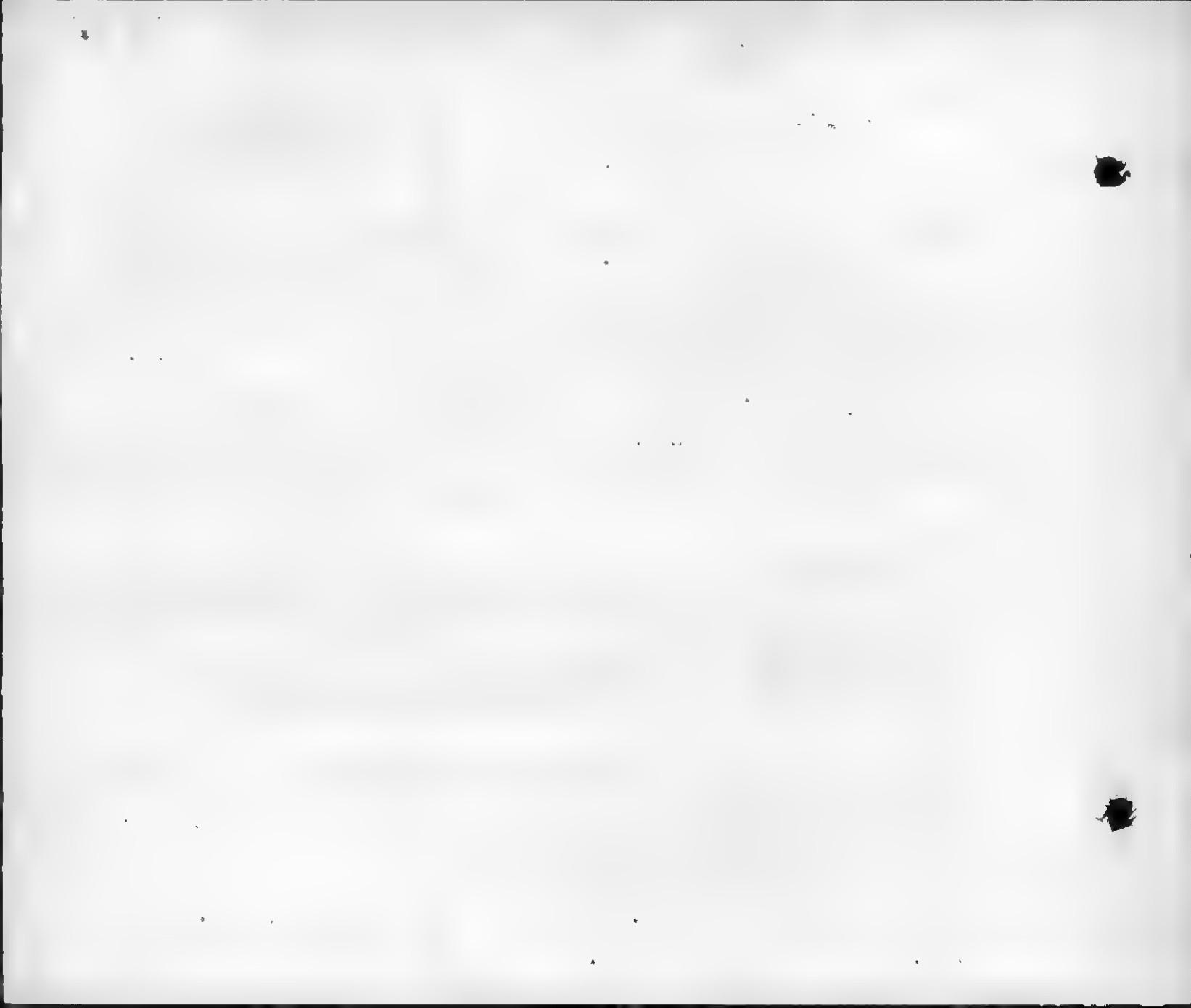
11172

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE  Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  rural—Finksburg		c. LENGTH OF STAY IN lb 35 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)  EARL		First W.	Middle JORDAN
4. DATE OF DEATH Month Oct	Day 15	Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-1902
9. AGE (In years last birthday) 56 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shoe stitcher	10b. KIND OF BUSINESS OR INDUSTRY shoe factory	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Walter L. Jordan	14. MOTHER'S MAIDEN NAME Anna Elizabeth Parrish	Address Same	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no	16. SOCIAL SECURITY NO. 213-01-9200	17. INFORMANT Mrs. Hilda Jorden,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581n DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema, left lung Attectasis, (c) Chronic liver, Mild Ascites		INTERVAL BETWEEN ONSET AND DEATH AUG 58 to 13 OCT 58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <u>Aug</u> , 1958, to <u>OCT</u> , 1958, that I last saw the deceased alive on <u>15 Oct</u> , 1958, and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) HOWARD E. HALL	ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>15 Oct 58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-19-1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Pleasant	22d. LOCATION (City, town, or county) (State) Gamber, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. N. Waltz, Winfield, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 20 58	24b. REGISTRAR'S SIGNATURE John S. Ward

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11173				
11183 CERTIFICATE OF DEATH										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>					2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>					b. COUNTY <b>Allegany County</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>					c. LENGTH OF STAY IN lb <b>1 mo. 3 days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Little Orleans Md.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>					d. STREET ADDRESS <b>None</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Credy</b>		Middle <b>KERLEY</b>		Last		4. DATE OF DEATH <b>October 12, 1878</b>		Month <b>October</b>	Day <b>8,</b>	Year <b>1958</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 12, 1878</b>		9. AGE (In years last birthday) <b>79</b> yrs		IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad worker</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>					11. BIRTHPLACE (State or foreign country) <b>Unknown</b>				
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO <b>- - -</b>					17. INFORMANT <b>Springfield Hospital Records</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abscess of lung</b>										INTERVAL BETWEEN ONSET AND DEATH Weeks				
521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Springfield</b>		(County) <b>Montgomery</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>September 5, 1958</b> , to <b>October 8, 1958</b> , that I last saw the deceased alive on <b>October 8, 1958</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>10/8/58</b>				
ACTUAL SIGNATURE <i>Agustin del Campo</i> M.D. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>										22d. LOCATION (City, town, or county) <b>Ridge Hwy Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					22b. DATE THEREOF <b>10/11/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) <b>Ridge Hwy Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Brownson</i>					ADDRESS <b>9 Gallins St.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 9 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knobell</i>					
VS AHS (4) 1SM 9/55														



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11184

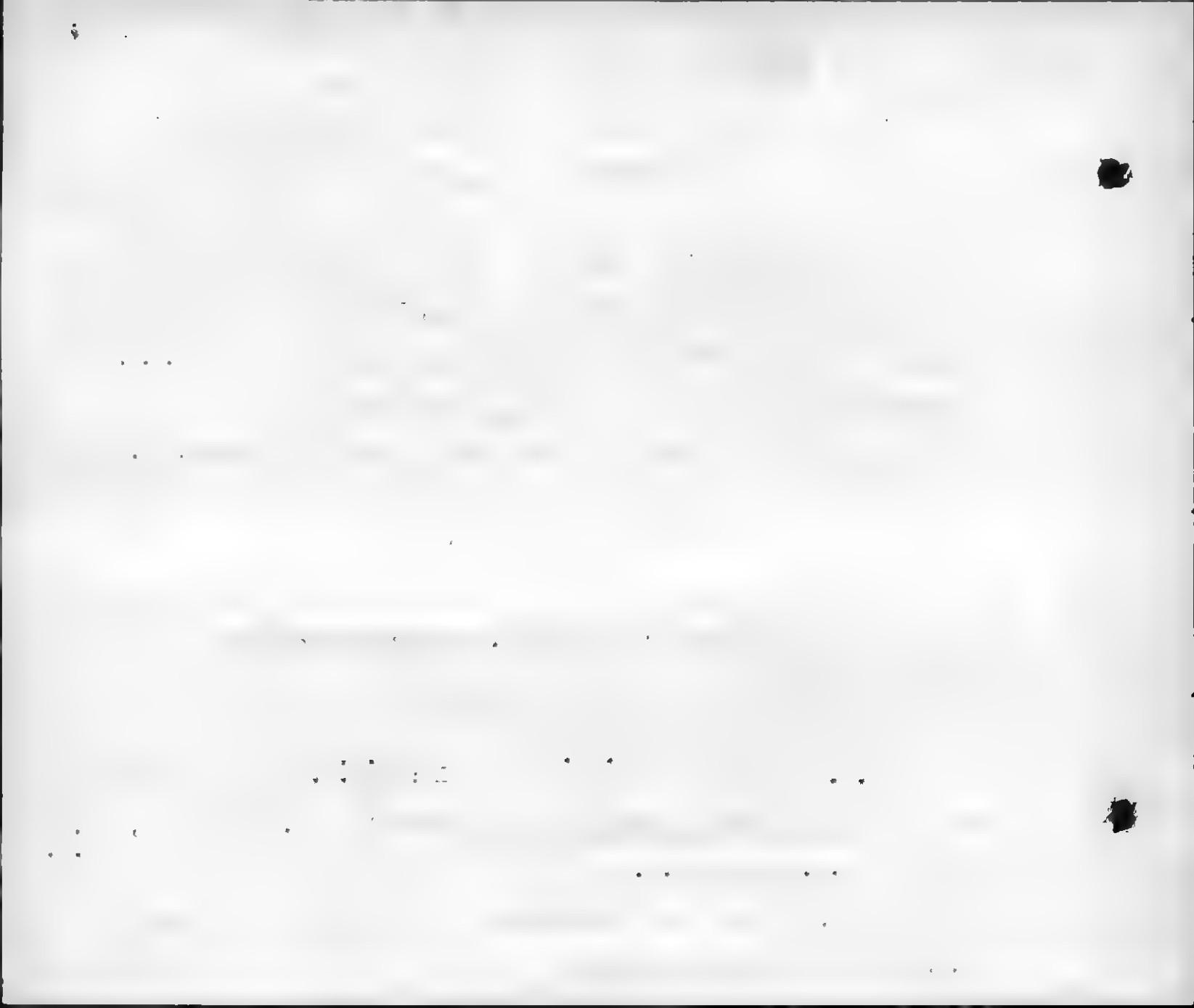
## CERTIFICATE OF DEATH

11174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived, if institution Residence before admission] a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Detour</b>		c. LENGTH OF STAY IN lb <b>1½ years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Detour</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>James Alfred Kiser</b>		First	Middle	Last	4. DATE OF DEATH <b>October 6,</b>	Month	Day	Year <b>19 58</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <b>October 26, 1868</b>	9. AGE (In years last birthday) <b>89 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Hours	12. IF UNDER 24 HRS Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Kiser</b>				14. MOTHER'S MAIDEN NAME <b>Alice Rowe</b>		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Carroll Dougherty</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>'420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Arteriosclerotic Nephritis. Cerebral Hemorrhage.</b>			20. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
21. I certify that I attended the deceased from <b>5.21.40</b> , 19, to <b>10.6.58</b> , 19, that I last saw the deceased alive on <b>10.5.58</b> , 19, and that death occurred at <b>10:25 P.M.</b> from the causes and on the date stated above.					ADDRESS (Street, city or town, state)			DATE SIGNED					
ACTUAL SIGNATURE <i>R. S. McVaugh</i>								<b>10.7.58</b>					
PHYSICIAN'S NAME (Type) <b>R. S. McVaugh M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 9, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Keysville Cemetery</b>		22d. LOCATION (City, town, or county) <b>Keysville, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry C. Fuss</i>		ADDRESS <b>C.O. Fuss &amp; Son, Taneytown, Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 9 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11175

11185

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>1 mo. 17 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>115 S. Conklin Street</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <b>Albert</b>	Middle <b>John</b>	Last <b>Kuhn</b>	4. DATE OF DEATH <b>October 17</b>	Month Day Year 19 58
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1912</b>	9. AGE (In years from birth) <b>46 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry Kuhn</b>			14. MOTHER'S MAIDEN NAME <b>Frances Schroeder</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>8</b>	17. INFORMANT Address <b>Springfield State Hospital Records</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 471A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>days</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with convulsive disorder, mental deficiency without psychosis</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in detail or give brief statement) <b>due to epidemic encephalitis.</b>			
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>19</b>	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>July 30</b> , 19 <b>58</b> to <b>October 17</b> , 19 <b>58</b> that I last saw the deceased alive on <b>October 17</b> , 19 <b>58</b> , and that death occurred at <b>9:00 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>10/17/58</b>					
ACTUAL SIGNATURE <i>Agustín del Campo</i>	M.D.				
PHYSICIAN'S NAME (Type) <b>Agustín del Campo, M.D.</b>	Sykesville, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct 20, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Schwartz Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b>		ADDRESS <b>3000 E. Baltimore St.</b>	24a. REC'D BY REGISTRAR DATE <b>OCT 2 58</b>	24b. REGISTRAR'S SIGNATURE <b>Theresa S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



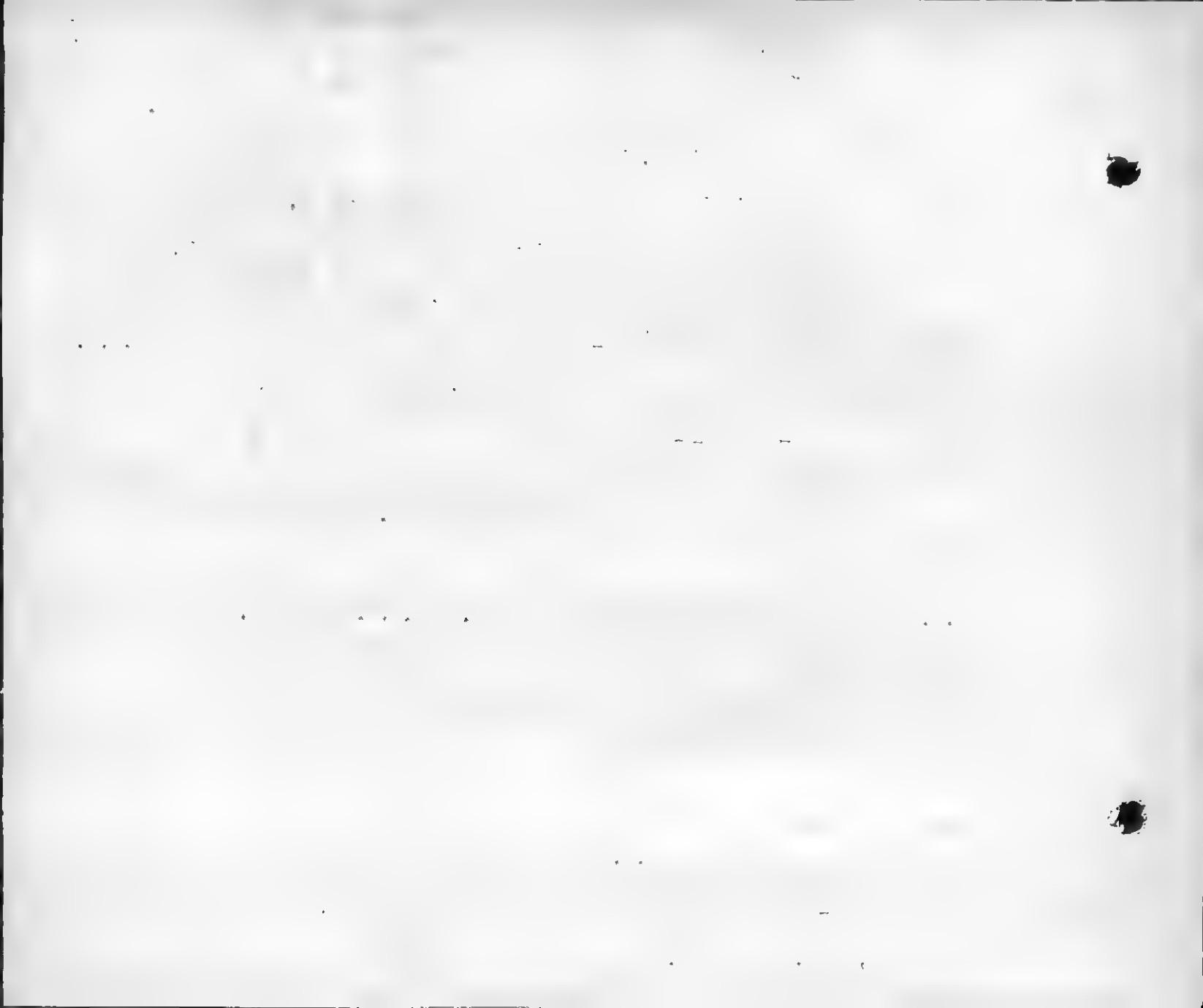
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11186 CERTIFICATE OF DEATH

Reg. Dist. No. 11176

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Balt. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 4 mos. 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Frank) Francis		First Middle Last	4. DATE OF DEATH October 27, Month Day Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1889
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Truck Helper		10b. KIND OF BUSINESS OR INDUSTRY Gunther's Brewerry -	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Leikam		14. MOTHER'S MAIDEN NAME Unknown Mary (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 220-14-3610A	17. INFORMANT Springfield Hospital Records Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Infarction of myocardium from coronary thrombosis due to arteritis.		INTERVAL BETWEEN ONSET AND DEATH Weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. due to arteriosclerotic heart disease. C.N.S. Syphilis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 10, 1958, to October 27, 1958, that I last saw the deceased alive on October 27, 1958, and that death occurred at 9:27 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Springfield State Hospital 10/27/58	
ACTUAL SIGNATURE Agustin del Campo, M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-30-58	22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery
22d. LOCATION (City, town, or county) 7401 German Hill Road		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR OCT 29 '58	24b. REGISTRAR'S SIGNATURE C. L. Kraus



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File 10235 10-21-58 et

11177

11187

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>22 yr. 1 mo. 2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Luigi</b>	Middle	Last <b>Lieto</b>	4. DATE OF DEATH <b>October 7</b>	Month	Day <b>19</b>	Year <b>58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>August 19, 1896</b>	9. AGE (In years last birthday) <b>64 62 rs.</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Days <b>62</b>	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. <b>Yuk</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatoma</b> 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, paranoid type.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>October 7, 1958</b> , that I last saw the deceased alive on <b>October 7, 1958</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Agustin del Campo</i>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital, Sykesville, Maryland, 10/7/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/10/58</b>		22c. NAME OF CEMETERY OR Crematory <b>New Catholic</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Haight, Sykesville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>OCT 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Clyde S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11188 CERTIFICATE OF DEATH**

Reg. Dist. No.

11178

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--westminster</b>		c. LENGTH OF STAY IN lb <b>6mo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Westminster</b>		d. STREET ADDRESS <b>R.D. # 6</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MARIE</b>		First	Middle	Last	4. DATE OF DEATH <b>Oct 6 1958</b>	Month	Day	Year		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	8. DATE OF BIRTH <b>4-11-1893</b>	9. AGE (in years last birthday) <b>65 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>Elgouis Doster</b>		14. MOTHER'S MAIDEN NAME <b>Annie r. Gillard</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Mrs. Arthur C. Shipley, Sr.</b>		Address <b>Same</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A. S. C. V. Disease</b>		DUE TO <b>422.1</b>				INTERVAL BETWEEN ONSET AND DEATH <b>21-21-1</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>105 E MAIN St.</b>		20f. (City or town) <b>Carroll Co.</b>		(County) <b>Md.</b>	(State) <b>MD</b>	
21. I certify that I attended the deceased from <b>James J. Moran</b> , M.D., on <b>Oct. 4, 1958</b> , to <b>Oct. 4, 1958</b> , that I last saw the deceased alive on <b>Oct. 4, 1958</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>James J. Moran</b>		ADDRESS (Street, city or town, state) <b>105 E MAIN St., WESTMINSTER MD</b>							DATE SIGNED <b>10/6/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-8-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Harmony Grove</b>		22d. LOCATION (City, town, or county) <b>Carroll Co.</b>		(State) <b>MD</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. L. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 8 58</b>		24b. REGISTRAR'S SIGNATURE <b>James J. Moran</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11179

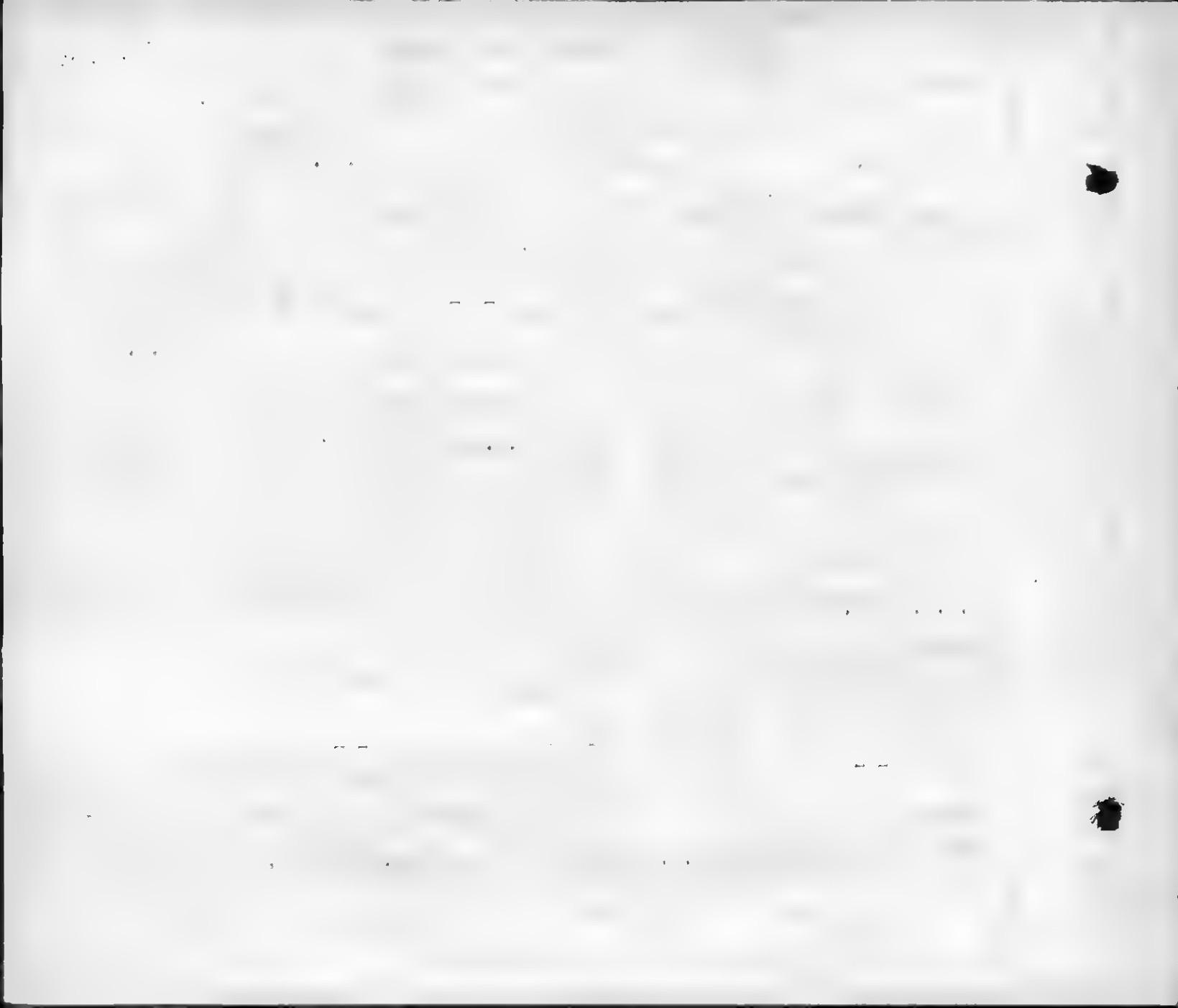
## 11189 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission] a. STATE Maryland b. COUNTY City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville,</b>	c. LENGTH OF STAY IN 1b <b>1m 12 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14, Md.</b> 3 Vol 4				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>4701 Catalpha Road</b>				
3. NAME OF DECEASED (Type or print) <b>Laura</b>	First <b>L.</b> Middle <b>Mishenke</b>	4. DATE OF DEATH <b>10</b> Month <b>10</b> Day <b>4</b> Year <b>19 58</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 9-12-07</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			
13. FATHER'S NAME <b>Harry Leibold</b>		14. MOTHER'S MAIDEN NAME <b>Alice Raybold</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no or unknown] <b>No</b>		16. SOCIAL SECURITY NO <b>unkn</b>	17. INFORMANT <b>S.S. Hospital Records</b>			
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriolar nephrosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>446x</b> (b) DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>8-22-1958</b> , to <b>10-4-1958</b> , that I last saw the deceased alive on <b>10-4-1958</b> , and that death occurred at <b>8:20 A.M.</b> from the causes and on the date stated above.						
				ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				DATE SIGNED <b>10-4-58</b>		
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		Sykesville, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10-7-58</b>		22b. DATE THEREOF <b>10-7-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Parkwood Cem.</b>	22d. LOCATION (City, town, county) <b>Baltimore Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Luck</b>		ADDRESS <b>5305 Harford</b>	24a. REC'D BY REGISTRAR <b>UCP 7-38</b>		24b. REC'D STAR'S SIGNATURE <b>Arthur S. Knott</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11180

## 11180 CERTIFICATE OF DEATH

Reg. Dist. No. ....

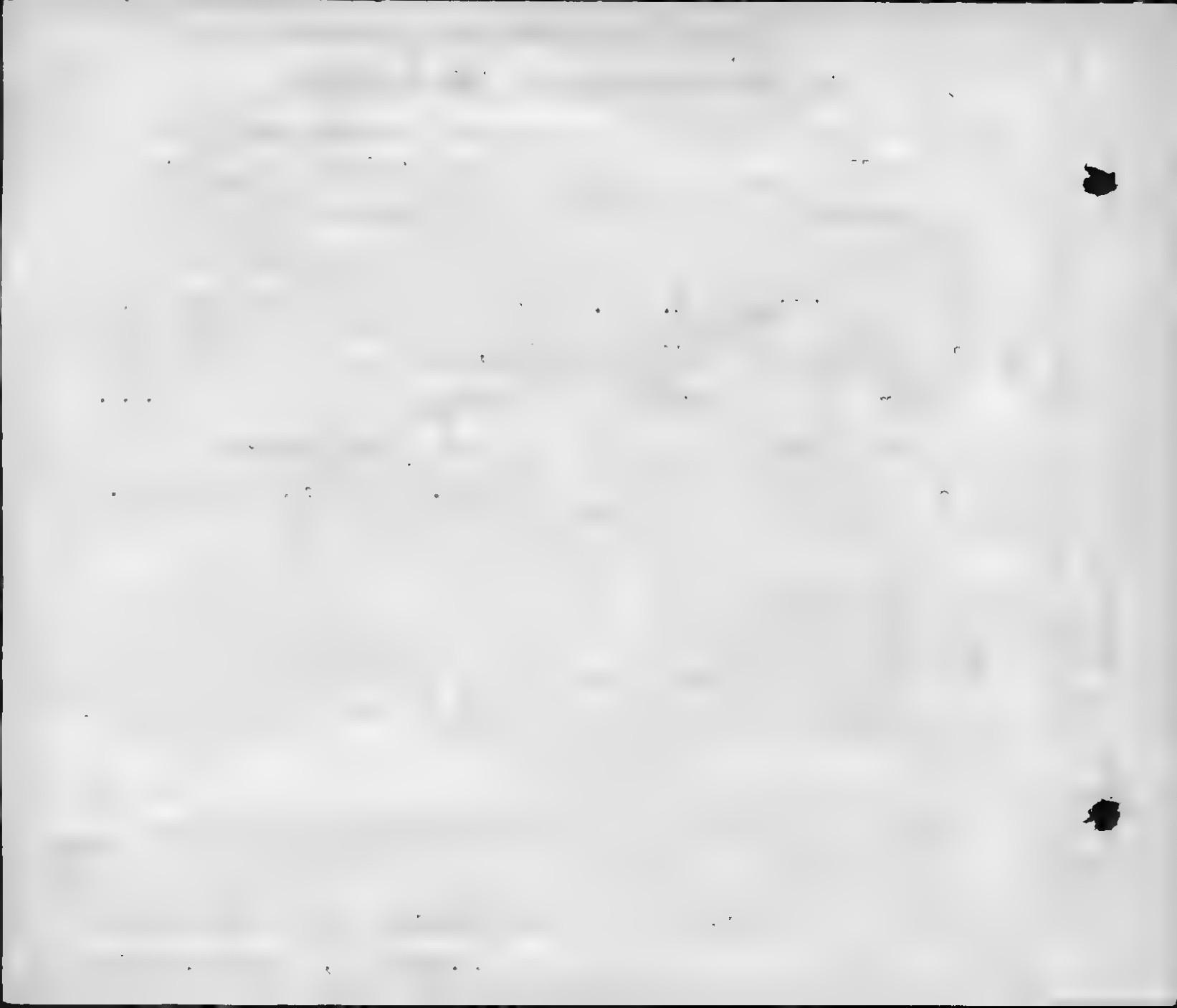
## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this has been done, the physician or hospital may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this has been done, the certificate assembly should be detached for use as a burial transit permit.

The bottom copy of this certificate should be retained by the funeral director, the third copy of this certificate should be filed in the funeral director's office.

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY Carroll CITY (If outside corporate limits, write RURAL OR give nearest town) TOWN Taneytown		STATE Maryland COUNTY Carroll CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Taneytown STREET ADDRESS (If rural give location) 15 York Street	
HOSPITAL OR (INSTITUTION OR STREET ADDRESS			
<b>3. NAME OF</b> (First) William C. N. Myers (Type or Print)		<b>4. DATE (Month) (Day) (Year)</b> OF DEATH October 26, 1958	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 30, 1879
9. AGE last birthday 79 yrs.	10. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jerome Myers	14. MOTHER'S MAIDEN NAME Sarah Jane Koontz		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Mr. Lloyd Myers, Taneytown, Md.	
<b>II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
IMMEDIATE CAUSE (A) <i>Myocarditis Chronic</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized Arteriosclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH</b>			
<i>Cancer Jaw (Tissue)</i>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 17, 1952, to Oct 26, 1958</u> , that I last saw the deceased alive on <u>Oct 17, 1958</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <i>E. Ambler Thompson M.D.</i> ADDRESS <u>Taneytown Md</u> DATE SIGNED <u>10/22/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>October 29, 1958</b>	NAME OF CEMETERY OR CREMATORIUM <b>Reformed Cemetery</b>	LOCATION (City, town, or county) <b>Taneytown, Maryland</b>
24. REC'D BY REGISTRAR <b>OCT 28 1958</b>	REGISTRAR'S SIGNATURE <i>in my office Kraus</i>	25. FUNERAL DIRECTOR'S SIGNATURE <b>C.O.Fuss &amp; Son, Taneytown, Maryland</b>	
DATE	ADDRESS		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11191

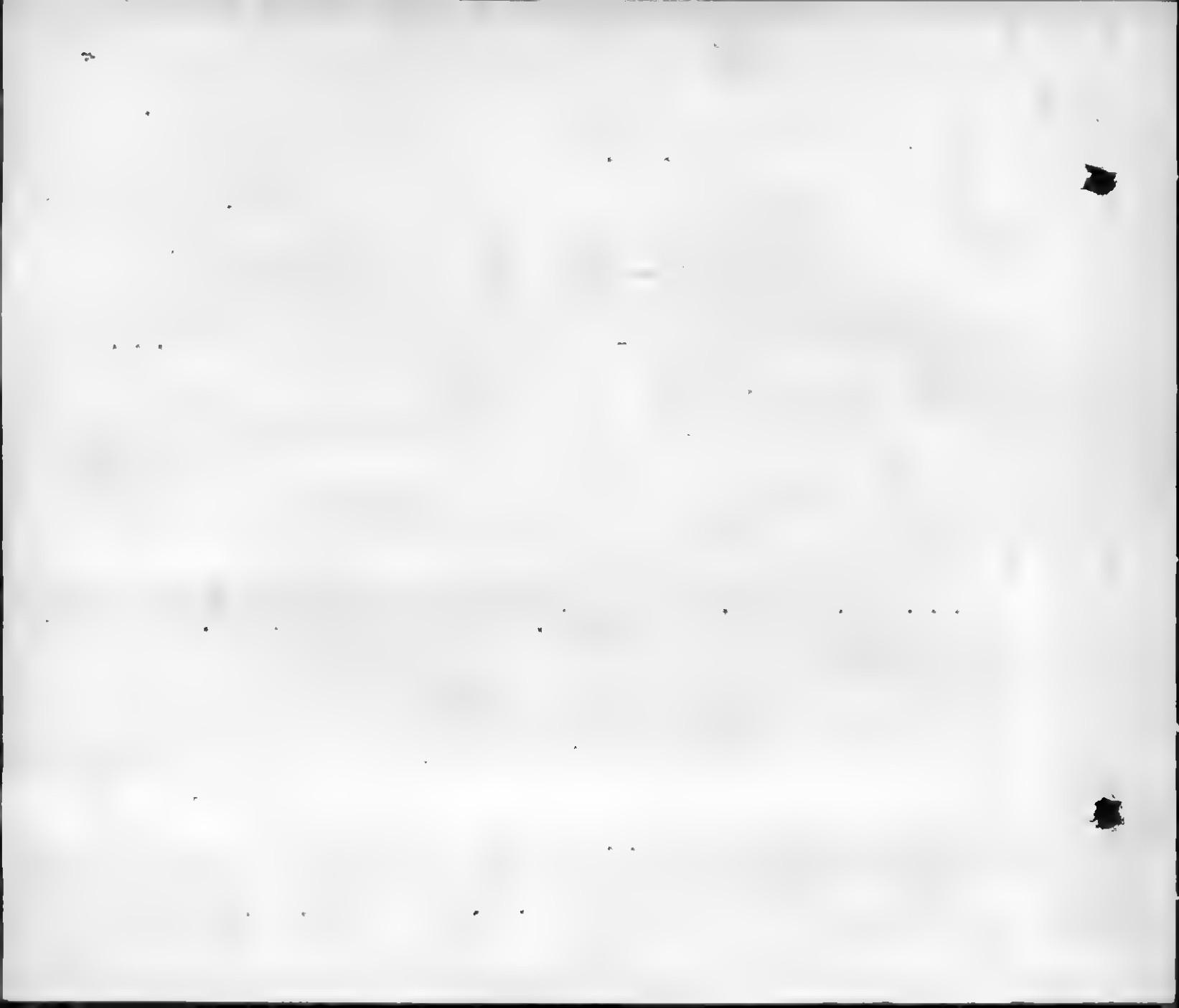
## CERTIFICATE OF DEATH

11181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		1. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr. 4mos. 20days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 34</b>	
d. STREET ADDRESS <b>9301 Old Harford Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>A</b>	Middle <b>Am</b>	Last <b>Gardiner</b>
4. DATE OF DEATH <b>October 8,</b>	Month <b>October</b>	Day <b>8,</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRITAL STATUS WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>November 14, 1876</b>
9. AGE (In years from birthday) <b>81</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John</b>	14. MOTHER'S MAIDEN NAME <b>John</b>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Branchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction, Fracture, neck of femur, right.</b>			
19. WAS AUTOPSY PERFORMED? <b>NO</b>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>494</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>
20f. (City or town) <b>-</b>		(County) <b>-</b> (State) <b>-</b>	
21. I certify that I attended the deceased from <b>May 18, 1958</b> , to <b>October 8, 1958</b> , that I last saw the deceased alive on <b>October 8, 1958</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		DATE SIGNED <b>10/9/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/11/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Moreland Mem. Pk.</b>	22d. LOCATION (City, town, or county) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Lickner &amp; Sons - Balt., Md.</i>		24a. ADDRESS <b>11181</b>	24b. REC'D BY REGISTRAR <b>OCT 14 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11192

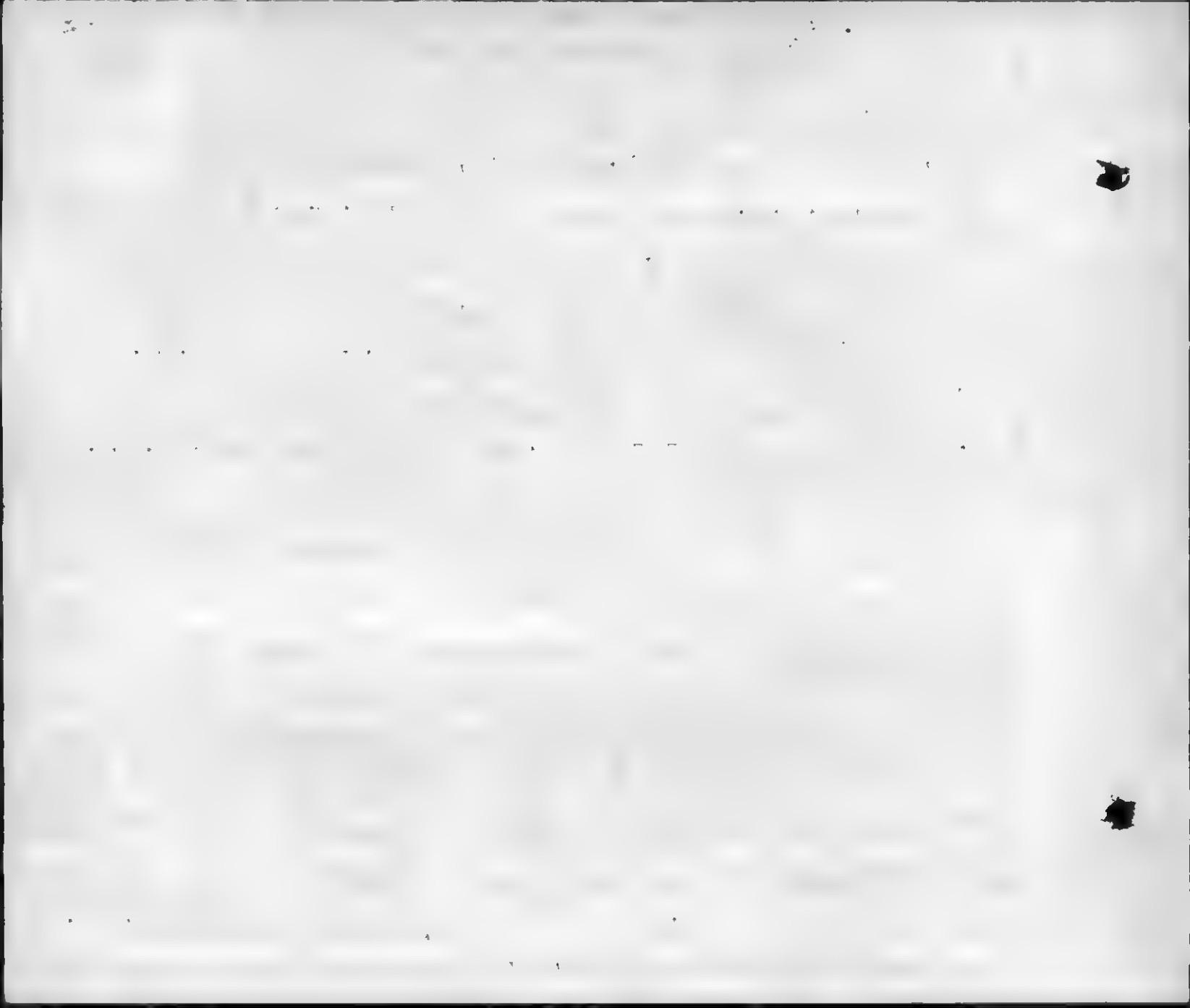
## CERTIFICATE OF DEATH

11182

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be attached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>		c. LENGTH OF STAY IN 1b <b>15 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R. D. 1</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>	
f. STREET ADDRESS <b>Westminster, Md. R. D. 1</b>		g. IS RESIDENCE ON A FARM? * YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Andy</b>	Middle <b>S.</b>	Last <b>Osborne</b>
4. DATE OF DEATH	Month <b>October</b>	Day <b>26</b>	Year <b>19 58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1881</b>
9. AGE (in years from last birthday) <b>77</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Parker, N.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Melvin Osborne</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Jane Breedlove</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b> (If yes, give war or date of service)	
16. SOCIAL SECURITY NO. <b>213-18-9199</b>		17. INFORMANT <b>Mrs. Bertha Osborne</b> Address <b>Mrs. Bertha Osborne, Westminster, Md. R.D.1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO  (c)		<i>Coronary Thrombosis</i>  <i>Coronary Sclerosis &amp;</i> <i>Arterio Sclerosis</i>	
		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. p. m.	Month <b>19</b>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1953</b> to <b>1958</b> , that I last saw the deceased alive on <b>Oct 17, 1958</b> and that death occurred at <b>12:01A</b> M, from the causes and on the date stated above.  ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type)		ADDRESS (Street, city, town, state)  <i>Alvemo Speicher, Westminster, Md. 10/28/58</i>	
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/28/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Marys Cemetery</b>	22d. LOCATION (City, town, or county)  <b>Silver Run, Carroll Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE  <i>Richard A. Little</i>		ADDRESS  <b>Littlestown, Pa.</b>	24a. REC'D BY REGISTRAR DATE  <b>OCT 28 1958</b>
		24b. REGISTRAR'S SIGNATURE  <i>Richard A. Little</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11193

## CERTIFICATE OF DEATH

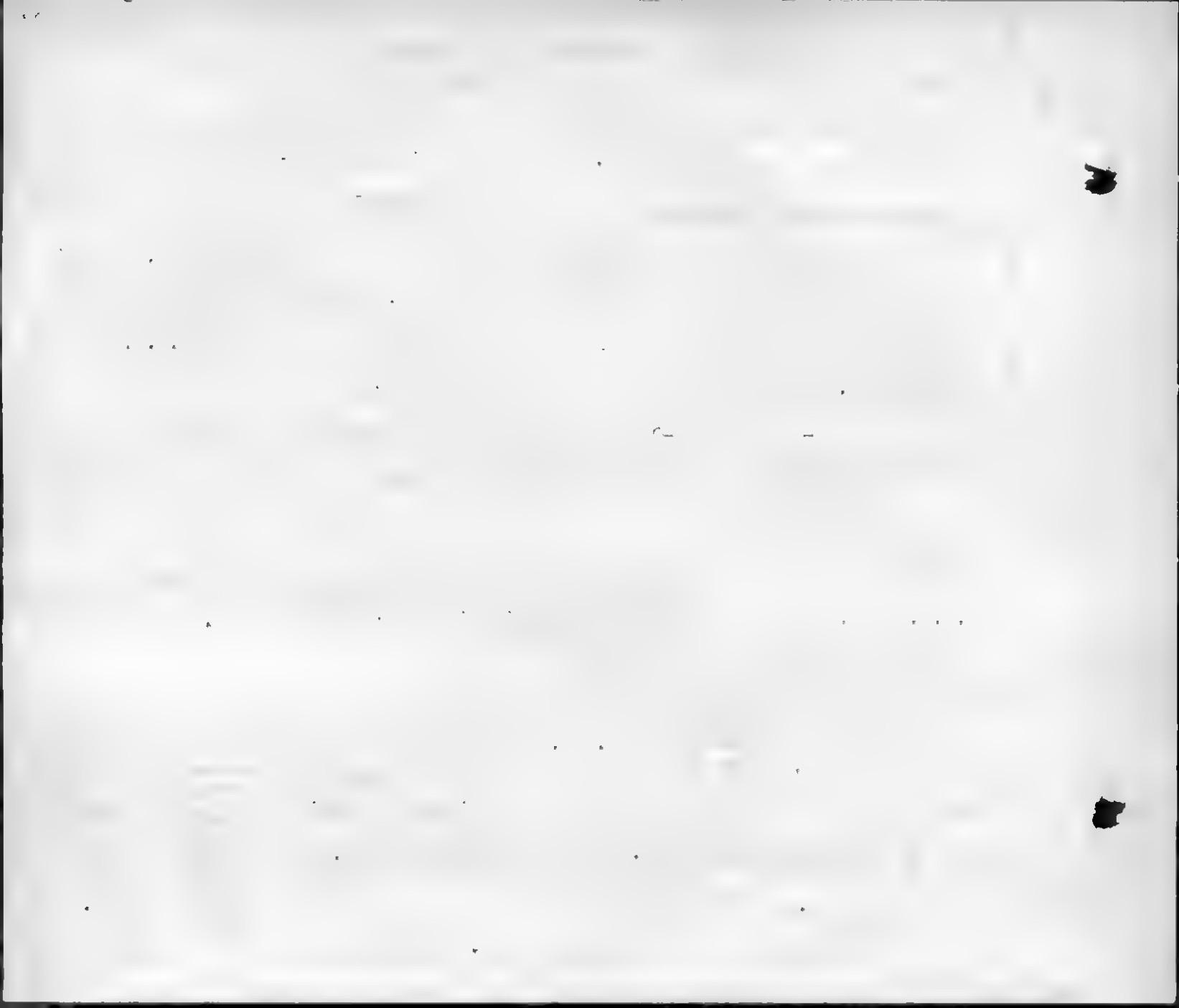
11183

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>10 mos. 14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Route #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Nettie Florence Duvall</b>	Middle <b>PURDUM</b>	Last	4. DATE OF DEATH <b>October 6, 1958</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 20, 1893</b>	9. AGE (in years last birthday) <b>65 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Zachariah T. Duvall</b>		14. MOTHER'S MAIDEN NAME <b>Marian Ward</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>577-03-6502-D</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH Years	
<b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield Hospital</b>	20f. (City or town) <b>Woodfield</b>	(County) <b>Md.</b>
21. I certify that I attended the deceased from <b>Nov. 22, 1957</b> , to <b>October 6, 1958</b> , that I last saw the deceased alive on <b>October 5, 1958</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>10/6/58</b>	
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>	PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		Sykesville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 8 58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Wesley Grove</b>		22d. LOCATION (City, town, or county) <b>Woodfield</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Roy W. Barber</i>		ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 9 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		



1

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in my event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		11194		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before adm'tn is on)	
Carroll		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Balt. City	
Sykesville		3 yrs. 10 mos. 20 days		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Springfield State Hospital		1538 Stonewood Rd.		f. DATE OF DEATH October 29, 1958	
3. NAME OF DECEASED (Type or print)		First May	Middle Belle	Month	Year
		Lantz	Reeve	Day	Year
3. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female		White	WIDOWED <input checked="" type="checkbox"/>	April 11, 1872	86 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry Lantz		Elizabeth Lantz		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		YNK		Address	
Springfield Hospital Records.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia					
491X DUE TO					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. C.B.S. assoc. with dist. of metabolism, growth or nutrition with senile brain disease with psychotic reaction. Fracture, comminuted, right femur.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 904.7					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Pushed to floor by another patient.					
20c. TIME OF INJURY Month, Day, Year 4:45 p.m. 10/15/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	
20f. (City or town) Sykesville		(County) Carroll		(State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James T. Marsh</i> M.D. DATE SIGNED 10/30/58					
EXAMINER'S NAME (Type) James T. Marsh, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial, casket 11-2-58		22b. DATE THEREOF 11-2-58		22c. NAME OF CEMETERY OR CREMATORIUM Hampton	
22d. LOCATION (City, town, or county) Hawthorne Iowa		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Wright</i>		ADDRESS C. J. Knobell, Esq.		24a. REC'D BY REGISTRAR DATE NOV 3 '58	
				24b. REGISTRAR'S SIGNATURE <i>C. J. Knobell</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11195

## CERTIFICATE OF DEATH

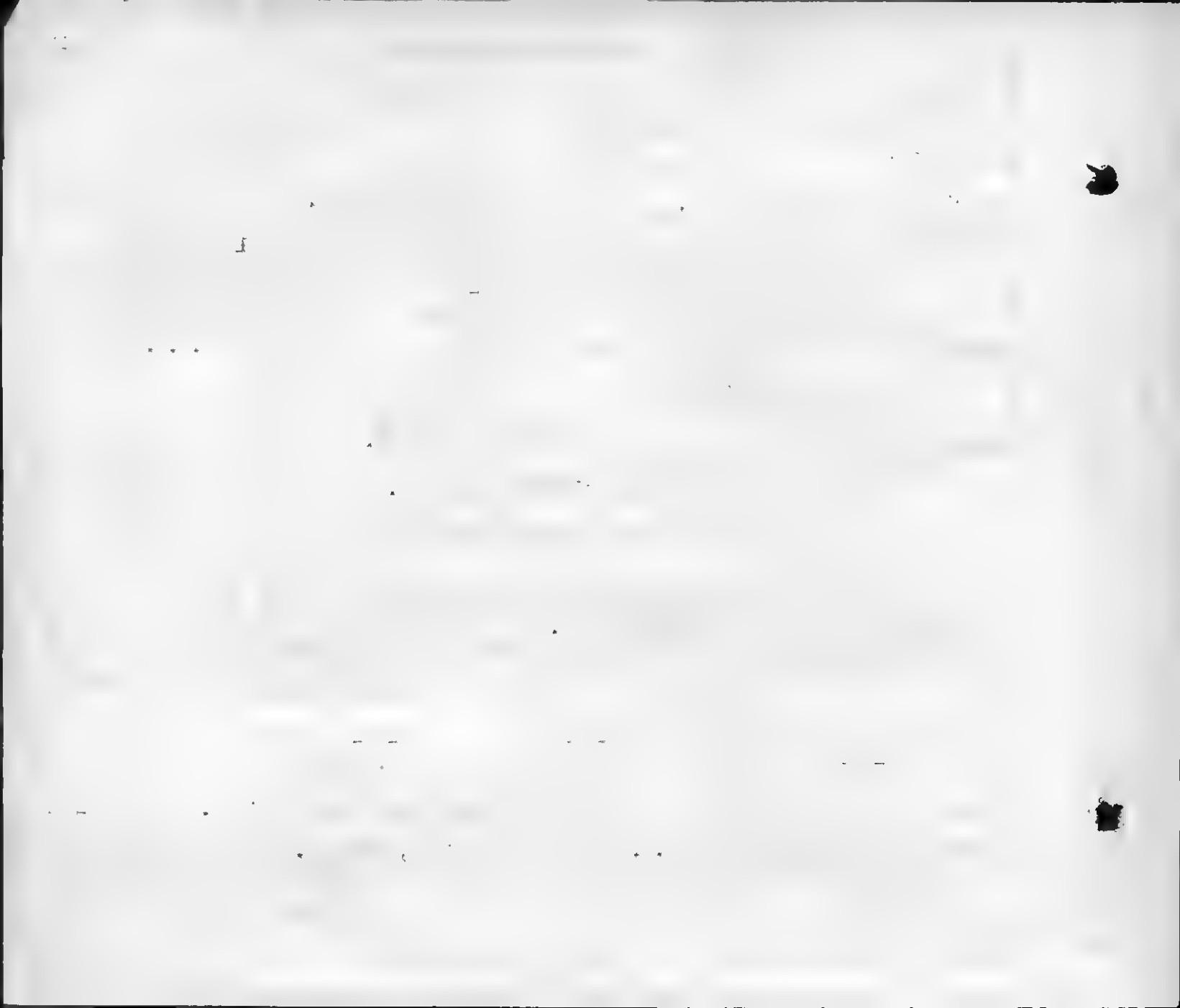
11185

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission 281 o. STATE Maryland b. COUNTY Washington County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville one year 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		e. STREET ADDRESS 225 Winter Street.	
3. NAME OF DECEASED (Type or print) Alvia		4. DATE OF DEATH Oct. 10 Month Day Year Reichard 25 1958	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown RETIRED ELEC. PLANT EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Theodore Reichard		11. BIRTHPLACE (State or foreign country) Germany	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] (If yes, give war or date of service) Unknown 1/6		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 40.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain syndrome associated with arteriosclerosis and circulatory disturbances with psychotic reactions.		years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-18-57, 19 to 11-25, 1958, that I last saw the deceased alive on 11-25, 1958, and that death occurred at 9:35 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Agustin del Campo M.D.		DATE SIGNED 11-26-58	
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10/28/58		22b. DATE THEREOF Rose Hill Cemetery	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Hagerstown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.J. Norment, Hagerstown, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR OCT 28 '58	
		24b. REGISTRAR'S SIGNATURE Charles & Anna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## 11196 CERTIFICATE OF DEATH

11186

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>1 m 14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (22), Md.</b>		d. STREET ADDRESS <b>6743 Woodley Rd</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Leonard</b>		First	Middle <b>Smith</b>	Last <b>Richardson</b>	4. DATE OF DEATH <b>10 19 1958</b>	Month	Day	Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>8 - 21 - 71</b>	9. AGE (In years last birthday) <b>87 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mill worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFG-12</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Helen Everson</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>A0N10 union</b>		17. INFORMANT <b>Springfield State Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH years <b>42 d. 1</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO  (c) DUE TO  (d) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with cerebral arteriosclerosis with senility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>St. Louis</b>		(County) <b>St. Louis</b>	(State) <b>MO</b>
21. I certify that I attended the deceased from <b>9 - 5 - 1958</b> , to <b>10 - 19 - 1958</b> , that I last saw the deceased alive on <b>10 - 18 - 1958</b> , and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		DATE SIGNED <b>10-19-58</b>							
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		Sykesville, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/23/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>UNION</b>		22d. LOCATION (City, town, or county) <b>St. Louis</b>		(State) <b>MO</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter L. Lusthaus, M.D.</b>		ADDRESS <b>6743 Woodley Rd, St. Louis, MO</b>		24a. REC'D BY REGISTRAR <b>Oct 21 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Finsen</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11197

## CERTIFICATE OF DEATH

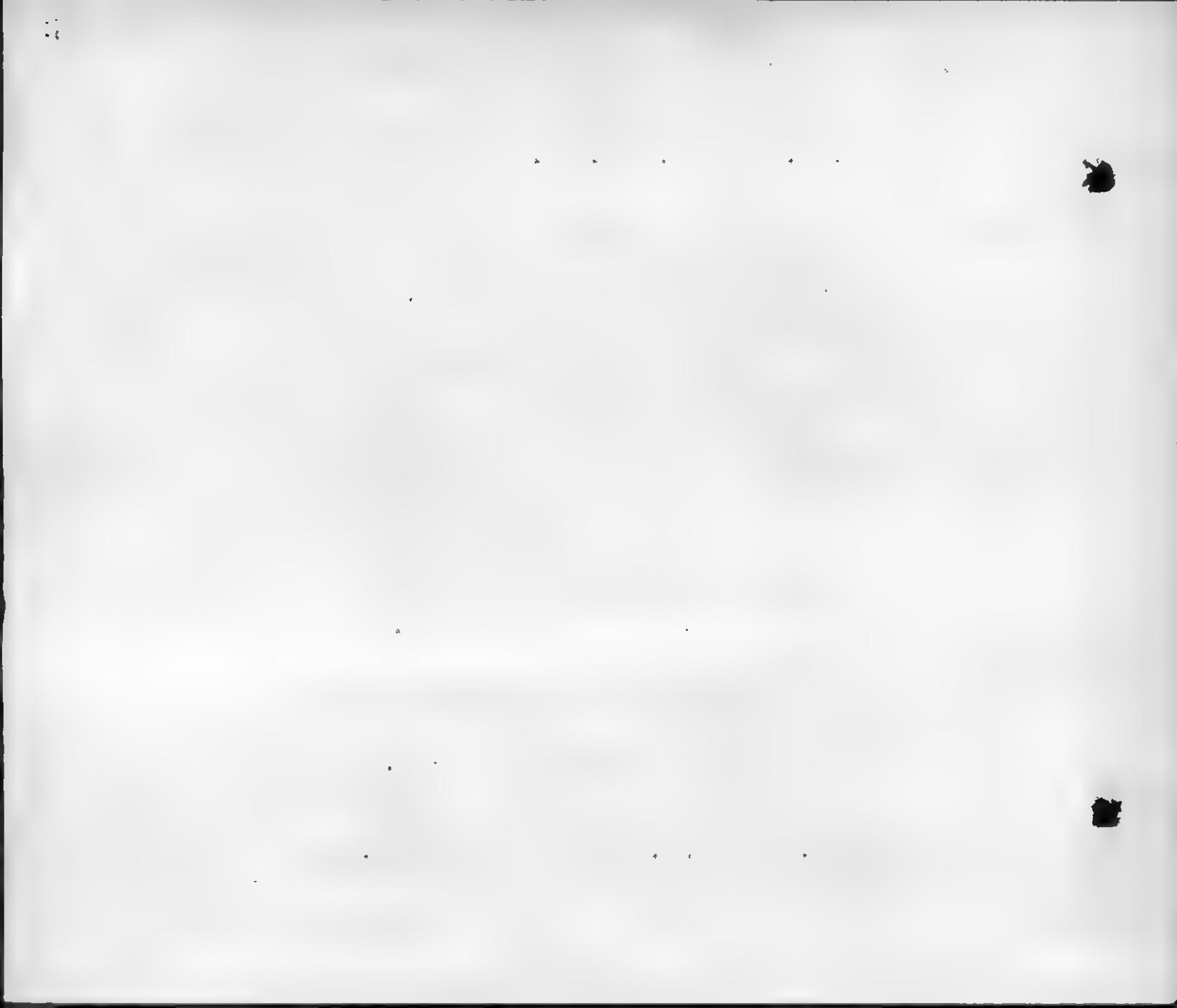
11187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Md.</b>		c. LENGTH OF STAY IN 1b <b>4 y. 10 m. 3 d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>4700 Harford Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Anna</b>		First	Middle	Last	4. DATE OF DEATH <b>October 7, 1958</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 6, 1873</b>	9. AGE (In years from birthday) <b>85 yrs</b>	10. IF UNDER 1 YEAR Months <b>85</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown U.S.</b>		
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No; Unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Springfield State Hospital Record</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH <b>days</b>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO <b>aspiration of food</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>chronic Rheumatic Heart Disease</b>		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic b.e.n syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychiatric reaction.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> Wk. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>July 1, 1957</b> , to <b>October 7, 1958</b> , that I last saw the deceased alive on <b>October 7, 1958</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Rita S. Glahn</b>		M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>10/7/58</b>		
PHYSICIAN'S NAME (Type) <b>Rita S. Glahn, M. D.</b>				Sykesville, Maryland				
22a. BURIAL, CREMATION, REMOVAL OR SPECIFY <b>Burial Oct. 10, 1958, Holy Redeemer</b>		22b. DATE THEREOF <b>Oct. 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Redeemer</b>		22d. LOCATION (City, town or county) <b>Baltimore</b>		(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clyde Glahn</b>		ADDRESS <b>Abbe Avenue 6067 Harf. Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Clyde S. Frank</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22C Film 6235 10/29/58

11164

## CERTIFICATE OF DEATH

Reg. Dist. No.

11188

1. PLACE OF DEATH: a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN 1b <i>3 mos</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster Md.</i>		d. STREET ADDRESS <i>229 E. Main Street.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>229 E. Main Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>John E. Sandbower</i>		First	Middle	Last	4. DATE OF DEATH Oct 24 1958	Month	Day	Year			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>15/15/1879</i>		9. AGE (In years lost birthday) <i>79 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Minister</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Meth. Min.</i>		11. BIRTHPLACE (State or foreign country) <i>Cumberland Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Frank. Sandbower</i>		14. MOTHER'S MAIDEN NAME <i>Anne Le Gaurd</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Son - Mrs. Sandbower 229 Westminster main St.</i>					
17. INFORMANT <i>None</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Leukemia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <i>About 1 yr.</i>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>		23. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ <i>19</i>		24. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>85 W. Green St.</i>	26. (City or town) <i>Westminster</i>	(County) <i>Cumberland</i>	(State) <i>Md.</i>
27. I certify that I attended the deceased from <i>Aug 1 1958</i> to <i>Oct 24 1958</i> , that I last saw the deceased alive on <i>Oct 24 1958</i> , and that death occurred at 9:00 A.M. from the causes and on the date stated above.		28. ADDRESS (Street, city or town, state) <i>85 W. Green St.</i>		29. DATE SIGNED <i>10/24/58</i>							
ACTUAL SIGNATURE <i>Julius Chepko</i>		30. PHYSICIAN'S NAME (Type) <i>Julius Chepko</i>		31. DATE OF CREMATION, EXHAUSTION (Specify) <i>Burial 10/29/58</i>		32. DATE THEREOF <i>10/29/58</i>		33. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>		34. LOCATION (City, town, or county) <i>Cumberland - Md.</i>	
35. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein</i>		36. ADDRESS <i>119 Franklin St.</i>		37. REC'D BY REGISTRAR <i>OCT 27 '58</i>		38. DATE <i>OCT 27 '58</i>		39. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

10. HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 2-220  
1SM 9/55



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

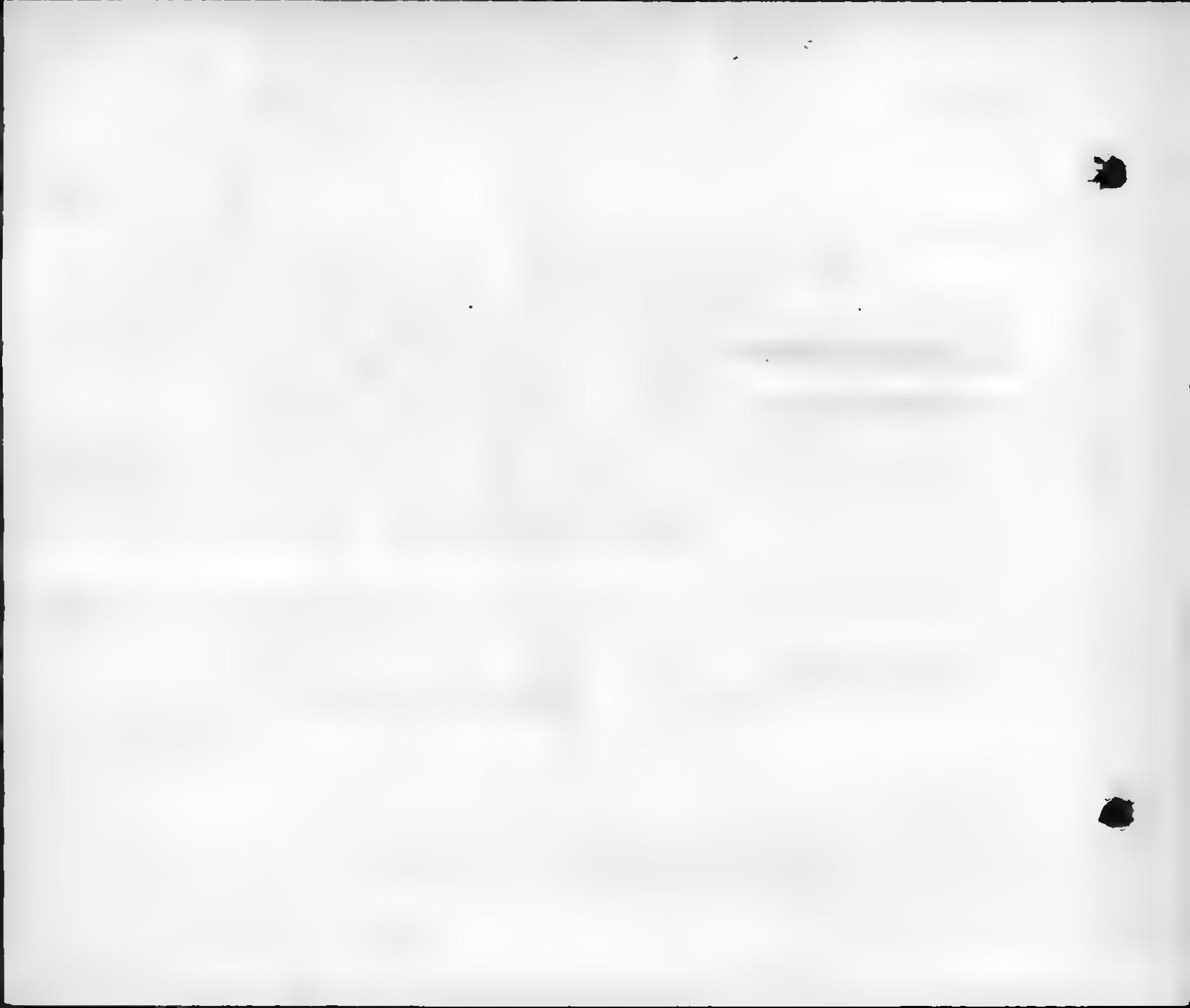
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11198 CERTIFICATE OF DEATH

11189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll Co</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i>		c. LENGTH OF STAY IN 1b <i>4 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i>		d. STREET ADDRESS <i>Westminster Rd. #2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Westminster Md. Rd #2</i>				e. STREET ADDRESS <i>Westminster Rd #2</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CHRISTINE ANNA SCOTT</i>		First	Middle	Last	4. DATE OF DEATH Month <i-oct.< i=""></i-oct.<>	Day <i>31</i>	Year <i>1958</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>May 15, 1877</i>	9. AGE (In years last birthday) <i>77 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Switchboard operator hotel</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) <i>Morrisville, N.Y.</i></i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Napoleon Rock</i>		14. MOTHER'S MAIDEN NAME <i>Mary Sorrell</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-03-9822</i>		17. INFORMANT <i>Mrs. R. L. Hoban, Westminster Md Rd #2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>						INTERVAL BETWEEN ONSET AND DEATH <i>7 hours</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>		DUE TO <i>a.s.c.v. disease &amp; hypertension</i>				years	
(c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Westminster</i>		20f. (City or town) (County) (State) <i>Baltimore</i>	
21. I certify that I attended the deceased from <i>Oct 31</i> , 1958, to <i>Oct 31</i> , 1958, that I last saw the deceased alive on <i>Oct 31</i> , 1958, and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Westminster</i>	
ACTUAL SIGNATURE <i>James T. Marsh</i>						DATE SIGNED <i>11/1/58</i>	
PHYSICIAN'S NAME (Type) <i>James T. Marsh</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 4, 58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers Jr. Westminster Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>NOV 8 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Cath. &amp; S. Russ</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 File 235 11-5-58 et

11165

## CERTIFICATE OF DEATH

Reg. Dist. No.

11190

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>	c. LENGTH OF STAY IN lb <i>54 yrs.</i>	b. COUNTY <i>Carroll</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>???</i>	d. STREET ADDRESS <i>29 E Green St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>CHARLES</i>	First <i>SILAS</i>	Middle <i>SEBOURE</i>	Last					
4. DATE OF DEATH <i>OCT. 30 1958</i>	Month	Day	Year					
5. SEX <i>M</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>July 17/1874</i>					
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <i>84 yrs.</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>BALTIMORE MD. ?</i>					
		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>JOHN - SEBOURE</i>	14. MOTHER'S MAIDEN NAME <i>JULIA ANN SIXX</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes/no or unknown) <i>-no-</i>	16. SOCIAL SECURITY NO. <i>219-27-3621</i>	17. INFORMANT <i>BROTHER</i>	Address <i>318 GRANGER WESTMINSTER.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A.S.C.V Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>years</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year 1958	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Emmitsburg Franklin Hall.</i>	20f. (City or town) <i>Emmitsburg</i>	(County) <i>Carroll</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Apr 1957</i> to <i>Oct 30 1958</i> , that I last saw the deceased alive on <i>Oct 30 1958</i> , and that death occurred at <i>93 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Westminster Md.</i> DATE SIGNED <i>Oct 31 1958</i>								
ACTUAL SIGNATURE <i>James J. Marsh</i>	M.D.							
PHYSICIAN'S NAME (Type) <i>JAMES J. MARSH</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>1158</i>	22b. DATE THEREOF <i>1158</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mountain View Cemetery</i>		22d. LOCATION (City, town, or county) <i>Emmitsburg Franklin Hall.</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. Sopell Jr.</i>		ADDRESS <i>254 Main St. Westminster, Md.</i>	24a. REC'D BY REGISTRAR <i>NOV 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Orville S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 27 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11191

11193

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Oakland Road	
3. NAME OF DECEASED (Type or print)		First SADIE	Middle
4. DATE OF DEATH Oct. 14 1958		Last SHIPLEY	Month Day Year
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1919 39
9. AGE (In years - last birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? - Stevens		14. MOTHER'S MAIDEN NAME Anna Harvey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO 213-12-6289	
17. INFORMANT Mr. Howell Shipton Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Circumoral arrest, mustache to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Liver, lumbar vertebrae, pelvis, forearm } (c) Circumoral Cardiac arrest		INTERVAL BETWEEN ONSET AND DEATH 1958 to 14 Oct 58	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956, 19, to 14 Oct, 1958, that I last saw the deceased alive on 14 Oct, 1958, and that death occurred at 11: P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Howard E. Hale M.D.			
PHYSICIAN'S NAME (Type) HOWARD E. HALE		ADDRESS (Street, city or town, state) SYKESVILLE, MD. DATE SIGNED 14 Oct 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-18-58	
22c. NAME OF CEMETERY OR CREMATORIAL Bethesda		22d. LOCATION (City, town) or county (State) Glastonbury, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Knapp		ADDRESS	
24a. REC'D BY REGISTRAR DATE OCT 21 58		24b. REGISTRAR'S SIGNATURE Arthur J. Knapp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

## CERTIFICATE OF DEATH

11192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL COUNTY MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ROUTE #6 WESTMINSTER</b>		b. COUNTY <b>CARROLL</b>	
c. LENGTH OF STAY IN 1b <b>39 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ROUTE #6 WESTMINSTER</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS —	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MURRAY</b>	Middle <b>ROBERT</b>	Last <b>STEM JR</b>
4. DATE OF DEATH	Month <b>OCTOBER</b>	Day <b>8TH</b>	Year <b>1958</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 11, 1919</b>
9. AGE (In years last birthday) <b>39 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MD.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>MURRAY ROBERT STEM SR.</b>	14. MOTHER'S MAIDEN NAME <b>ETHEL ANNA TARBART</b>	Address <b>(SAM LIT ADDRESS)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>220-26-0364</b>	17. INFORMANT <b>WIFE MARIE WANTZ STEM</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>original site - Prostate</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 mo.</b>
Conditions, if any, which gave rise to immediate cause (b), stating the under-lying cause last. <b>17X</b> (b) DUE TO <b>original site - Prostate</b> (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>TAYLORSVILLE MD.</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 31, 1957</b> , to <b>10/8/58</b> , that I last saw the deceased alive on <b>10/7/58</b> , 19, and that death occurred at <b>4:58</b> A.M., from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <b>New Windsor, Md.</b> DATE SIGNED <b>10/8/58</b>		
ACTUAL SIGNATURE <b>M.E. Robertson</b>	PHYSICIAN'S NAME (Type) <b>Arthur S. Thomas</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>OCT. 11, '58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>TAYLORSVILLE NE. CEM. TAYLORSVILLE MD.</b>	22d. LOCATION (City, town, or county) (State) <b>TAYLORSVILLE MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James A. Self</b>	ADDRESS <b>234 E Main St. Westminster, Md.</b>	24a. REC'D BY REGISTRAR <b>OCT 14 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11201

## CERTIFICATE OF DEATH

11193

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Manchester</i>		c. LENGTH OF STAY IN 1b <i>17 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Manchester Rd #1</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carroll Manchester</i>			
f. STREET ADDRESS <i>Manchester Rd #1</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>LIZZIE</i>	Middle <i>BLACK</i>	Last <i>STERNER</i>		
4. DATE OF DEATH Month <i>Oct</i>	Month <i>11</i>	Day <i>1958</i>	Year		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 28 1882</i>		
9. AGE (in years from birth) <i>76 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Henry Black</i>	14. MOTHER'S MAIDEN NAME <i>Franca Keenrod</i>	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>None</i>	17. INFORMANT <i>Mrs Ester Sterner Manchester Rd #1</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary Arteriosclerosis</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Hypertensive Cardio-Vascular Disease</i> (c)	INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardiac Liver Cirrhosis; Simple goiter; Direct and indirect hernia; diabetes</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>260X</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>19</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>Hampstead, Md.</i>	(County) <i>Hampstead, Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>June 1943</i> to <i>10-10 1958</i> , that I last saw the deceased alive on <i>10/91 1958</i> , and that death occurred at <i>11-25 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Hampstead, Md.</i>					
ACTUAL SIGNATURE <i>M. C. Porterfield</i>	M.D.		DATE SIGNED <i>10.13.58</i>		
PHYSICIAN'S NAME (Type) <i>M. C. Porterfield, M.D.</i>	Hampstead, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct 14 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Manchester recd</i>	22d. LOCATION (City, town, or county) <i>Manchester</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. K. Smith</i>	ADDRESS <i>Han Rob, Esq.</i>	24a. REC'D BY REGISTRAR DATE <i>OCT 15 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11202

## CERTIFICATE OF DEATH

11194

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>CARROLL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER RURAL</b>		c. LENGTH OF STAY IN 1b <b>5 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X UNION BRIDGE</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLOVERS NURSING HOME</b>		d. STREET ADDRESS <b>BENEDUM ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>SADIE</b>	Middle <b>ELIZABETH</b>	Last <b>STONESIFER</b>	4. DATE OF DEATH <b>OCT 20 1958</b>	Month <b>OCT</b> Day <b>20</b> Year <b>1958</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 1 - 1867</b>	9. AGE (In years lost birthday) <b>91 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b> IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>JOHN BROWN</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE BROWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>POLAND STONESIFER</b>	
				Address <b>MD UNION BRIDGE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>multiple cerebral hemorrhages</b> DUE TO <b>arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>extensive debilitus ulcers</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1958</b> , to <b>Oct 20, 1958</b> , that I last saw the deceased alive on <b>Oct 20, 1958</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Reese Wilkens</b> ADDRESS (Street, city or town, state) <b>15 Temple Ave., Westminster, Md.</b> DATE SIGNED <b>10/21/58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/22/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>LUTHERAN</b>	
22d. LOCATION (City, town, or county) <b>TANEY TOWN</b>				(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. Hartley &amp; Sons Union Bridge</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>OCT 23 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Koenig</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11203 CERTIFICATE OF DEATH

11195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #3		c. LENGTH OF STAY IN 1b 74 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Dolores Irene Stremmel		4. DATE OF DEATH Oct 27 1958	5. SEX F
6. COLOR OR RACE Th		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY (If foreign, state or foreign country) None	
13. FATHER'S NAME Gerald Henry Stremmel		14. MOTHER'S MIDDLE NAME Viola Mae Helsley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None 17. INFORMANT Gerald Stremmel	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Measles - Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Oct 26 - died Oct 27 -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 13, 1958, to Oct 27, 1958, that I last saw the deceased alive on Oct 26, 1958, and that death occurred at 11:30 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE George P. And M.D. 139 Carlton St. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Carroll		22b. DATE THEREOF Oct 28 1958	
22c. NAME OF CEMETERY OR CRYSTALY Black Rock		22d. LOCATION (City, town, or county) Block Rock Co. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frederick Buckner, Elmer Sa		24a. REC'D BY REGISTRAR DATE OCT 28 1958	
		24b. REGISTRAR'S SIGNATURE Elmer S. Klaus	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 Items 20 & 21 Film MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
235 11-17-58 a.m.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11196

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMAs. Page 5 may be retained by the funeral director.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		11204 Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 2yrs. 8mos. 5days		d. STATE Maryland b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		f. STREET ADDRESS	
Springfield State Hospital		Camp Hill Severn		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Jeannette	Middle Griffith	DATE OF DEATH	Month October Day 19, Year 1958
4. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 16 YEARS IF UNDER 24 HRS
Female White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 20, 1879	79 yrs	Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		-		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> 16. SOCIAL SECURITY NO.	
Columbus Griffith		Emily Griffith		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Springfield Hospital Records			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Asphyxiation due to cause other than trauma			
921.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO (b) Choked on Piece of cake DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		Minutes Involutional psychotic reaction. Pulmonary tuberculosis.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Patient choked on a piece of cake.			
20c. TIME OF INJURY Month, Day, Year Hour 4:15 p.m. Oct 19-1958		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hosp. Carroll Md.	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>W.Glenn Speicher</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. W. Glenn Speicher		DATE SIGNED 10/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/58		22c. NAME OF CEMETERY OR CREMATORIAL Friendship	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopkins &amp; KIRKLEY, Glen Burnie, Md.</i>		ADDRESS		22d. LOCATION (City, town, or county) Anne Arundel Co. (State)	
24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE			
DATE OCT 23 '58					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

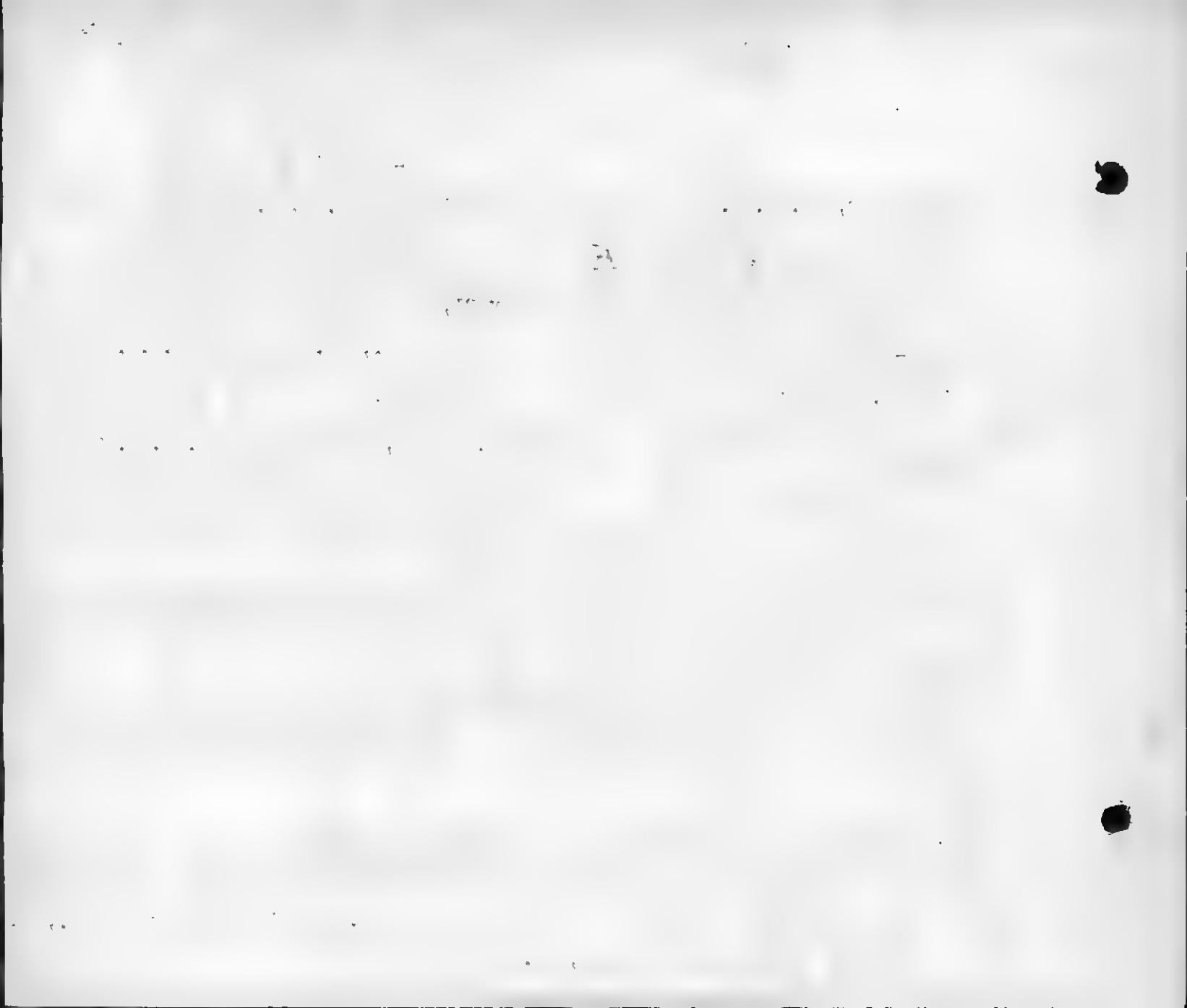
11197

FOR STATE  
HEALTH DEPT.

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11205				Reg. Dist. No. _____			
<p>1. PLACE OF DEATH            a. COUNTY <u>ARROLD</u></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Westminster</u></p> <p>c. LENGTH OF STAY IN lb <u>Life</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westminster, Md. R. D. 2</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission)            a. STATE Maryland b. COUNTY Carroll</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Westminster</u></p> <p>d. STREET ADDRESS <u>Westminster, Md. R. D. 2</u></p> <p>e. IS RESIDENCE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) <u>Goldia</u></p> <p>First <u>Belle</u> Middle <u>Wagner</u> Last <u>VAGNER</u></p> <p>4. DATE OF DEATH <u>Oct 12 1958</u></p>				<p>Month <u>Oct</u> Day <u>12</u> Year <u>1958</u></p>			
<p>5. SEX <u>Female</u> COLOR OR RACE <u>White</u></p> <p>MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>B. DATE OF BIRTH <u>July 21, 1892</u></p>		<p>9. AGE (In years last birthday) <u>66</u> yrs</p>		<p>IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u></p> <p>IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife-Housework</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Her own home</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Elias G. Shipley</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Virginia Pickett</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>None</u></p>		<p>17. INFORMANT <u>Paul W. Wagner</u> Address</p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes Mellitus</u> DUE TO <u>None</u> (c) <u>None</u></p>	
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 years</u>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <u>James T. Parsh</u> DATE SIGNDED <u>10/12/58</u></p> <p>EXAMINER'S NAME (Type) <u>James T. Parsh</u></p>							
<p>220. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>221. DATE THEREOF <u>10/15/58</u></p>		<p>222. NAME OF CEMETERY OR CREMATORIUM <u>Zion Cemetery</u></p>		<p>223. LOCATION (City, town, or county) (State) <u>Nr. Westminster, Carroll Co., Md.</u></p>	
<p>224. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u></p>		<p>ADDRESS <u>Littlestown, Pa.</u></p>		<p>245. REC'D BY REGISTRAR DATE <u>Oct 14 '58</u></p>		<p>246. REGISTRAR'S SIGNATURE <u>Richard A. Little</u></p>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11198

11166

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN lb <i>2 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		d. STREET ADDRESS <i>141 Bishop St</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>-</i>				d. STREET ADDRESS <i>141 Bishop St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>REBECCA - A - WAGNER</i>		First <i>A</i>	Middle <i>-</i>	Last <i>WAGNER</i>	4. DATE OF DEATH <i>Oct 4-1958</i>	Month <i>Oct</i>	Day <i>4</i>	Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 10-1863</i>	9. AGE (In years last birthday) yrs. <i>95</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work alone during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>		10c. BIRTHPLACE (State or foreign country) <i>Md</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth absaugh</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>700</i>		17. INFORMANT <i>Mrs. chas Mancha - Westminster Md</i>		18. INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) <i>cerebral thrombosis</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>arteriosclerosis unknown</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Wesley</i>		20f. (City or town) <i>Carroll Co Md</i>		(County) <i>Carroll Co</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>Sept 30, 1958</i> to <i>Oct 4, 1958</i> , that I last saw the deceased alive on <i>Oct 2, 1958</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. Reese Wilkens</i> ADDRESS (Street, city or town, state) <i>15 Kemper av. Westminster Md</i> DATE SIGNED <i>10/4/58</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 7-1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Wesley</i>		22d. LOCATION (City, town, or county) <i>Carroll Co Md</i>		(State) <i>Carroll Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Chilton Hempstead Md</i>		ADDRESS <i>Edgar Chilton Hempstead Md</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 8 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11206

## CERTIFICATE OF DEATH

11199

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>40 y. 2 m. 2d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		21032	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS —		e. DATE OF DEATH <b>October 24 1958</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Henry</b>	Middle <b>Newton</b>	Last <b>Wishard</b>	Month	Day	Year	
4. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Wishard</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Holbranner</b>		Address <b>Springfield Hospital Records</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service —							
16. SOCIAL SECURITY NO. —		17. INFORMANT Address <b>Springfield Hospital Records</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH 420.0 years DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>002X</b> (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, paranoid type. Pulmonary tuberculosis, far advanced, active.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>10/20/54</b> , 19, to <b>10/24/58</b> , 19, that I last saw the deceased alive on <b>10/24/58</b> , 19, and that death occurred at <b>3:10 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Julian Radzykewick, M.D.</i> DATE SIGNED <b>10/24/58</b>							
PHYSICIAN'S NAME (Type) <b>Julian Radzykewick, M.D.</b> Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Waynesboro</b> (State) <b>Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. Martin Poe</i>				ADDRESS <b>Waynesboro, Penna.</b>		24a. REC'D BY REGISTRAR <b>OCT 27 1958</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Krause</i>

## CERTIFICATE OF DEATH

51506

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